

14-057

ORIGINAL ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD RECEIVED

APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

HEALTH FACILITIES &
SERVICES REVIEW BOARD

Facility/Project Identification

Facility Name: Advocate Christ Medical Center – Trauma I Center/Emergency Department Expansion and Renovation			
Street Address: 4440 West 95 th Street			
City and Zip Code: Oak Lawn 60453-2699			
County: Cook	Health Service Area	7	Health Planning Area: A-04

Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: Advocate Health and Hospitals Corporation d/b/a Advocate Christ Medical Center	
Address: 4440 West 95 th Street Oak Lawn 60453-2699	
Name of Registered Agent: Gail D. Hasbrouck	
Name of Chief Executive Officer: Kenneth Lukhard, President, Advocate Christ Medical Center	
CEO Address: 4440 West 95 th Street Oak Lawn 60453-2699	
Telephone Number: 708-684-5010	

Type of Ownership of Applicant/Co-Applicant

☒ Non-profit Corporation	☐ Partnership
☐ For-profit Corporation	☐ Governmental
☐ Limited Liability Company	☐ Sole Proprietorship ☐ Other

- Corporations and limited liability companies must provide an **Illinois certificate of good standing**.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT-1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact

[Person to receive ALL correspondence or inquiries]

Name: Robert Harrison
Title: Market Vice President, Business Development
Company Name: Advocate Christ Medical Center
Address: 4440 West 95 th Street, Oak Lawn, IL 60453
Telephone Number: (708) 684-4274
E-mail Address: Robert.Harrison@advocatehealth.com
Fax Number: (708) 520-1820

Additional Contact

[Person who is also authorized to discuss the application for permit]

Name: Jeffrey So
Title: Regional Director, Business Development/Community Relations
Company Name: Advocate Christ Medical Center
Address: 9401 S. Pulaski, Suite 201, Evergreen Park, IL 60805
Telephone Number: (708) 684-5763
E-mail Address: Jeffrey.So@advocatehealth.com
Fax Number: (708) 684-5707

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Advocate Christ Medical Center – Trauma I Center/Emergency Department Expansion and Renovation			
Street Address: 4440 West 95 th Street			
City and Zip Code: Oak Lawn 60453-2699			
County: Cook	Health Service Area	7	Health Planning Area: A-04

Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: Advocate Health Care Network	
Address: 3075 Highland Parkway, Downers Grove, IL 60515	
Name of Registered Agent: Gail D. Hasbrouck	
Name of Chief Executive Officer: James H. Skogsbergh, President and Chief Executive Officer	
CEO Address: 3075 Highland Parkway, Downers Grove, IL 60515	
Telephone Number: 630-929-8700	

Type of Ownership of Applicant/Co-Applicant

☒ Non-profit Corporation	☐ Partnership
☐ For-profit Corporation	☐ Governmental
☐ Limited Liability Company	☐ Sole Proprietorship ☐ Other

- Corporations and limited liability companies must provide an **Illinois certificate of good standing**.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT-1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact

[Person to receive ALL correspondence or inquiries]

Name: Robert Harrison
Title: Market Vice President, Business Development
Company Name: Advocate Christ Medical Center
Address: 4440 West 95 th Street, Oak Lawn, IL 60453
Telephone Number: (708) 684-4274
E-mail Address: Robert.Harrison@advocatehealth.com
Fax Number: (708) 580-1820

Additional Contact

[Person who is also authorized to discuss the application for permit]

Name: Jeffrey So
Title: Regional Director, Business Development/Community Relations
Company Name: Advocate Christ Medical Center
Address: 9401 S. Pulaski, Suite 201, Evergreen Park, IL 60805
Telephone Number: (708) 684-5763
E-mail Address: Jeffrey.So@advocatehealth.com
Fax Number: (708) 684-5707

Additional Contact

[Person who is also authorized to discuss the application for permit]

Name: Wendy Mulvihill
Title: Planning Manager
Company Name: Advocate Christ Medical Center
Address: 9401 S. Pulaski, Suite 201, Evergreen Park, IL 60805
Telephone Number: (708) 684-5765
E-mail Address: Wendy.Mulvihill@advocatehealth.com
Fax Number: (708) 684-5707

Additional Contact

[Person who is also authorized to discuss the application for permit]

Name: Janet Scheuerman
Title: Senior Consultant
Company Name: PRISM Healthcare Consulting
Address: 1808 Woodmere Drive, Valparaiso, IN 46383
Telephone Number: (219) 464-3969
E-mail Address: jscheuerman@consultprism.com
Fax Number: (219) 464-0027

Additional Contact

[Person who is also authorized to discuss the application for permit]

Name: Joe Ourth
Title: Attorney
Company Name: Arnstein & Lehr, LLP
Address: 120 S. Riverside Plaza, Suite 1200, Chicago, IL 60606-3910
Telephone Number: (312) 876-7815
E-mail Address: jourth@arnstein.com
Fax Number: (312) 876-6215

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance-**THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960**

Name: Albert Manshum
Title: Vice President, Facilities and Construction
Company Name: Advocate Health Care
Address: 3075 Highland Parkway, Downers Grove, IL 60515
Telephone Number: (630) 929-5575
E-mail Address: Albert.Manshum@advocatehealth.com
Fax Number: (630) 929-9905

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Advocate Health and Hospitals Corporation
Address of Site Owner: 3075 Highland Parkway, Downers Grove, IL 60515
Street Address or Legal Description of Site: Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.
APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

[Provide this information for each applicable facility, and insert after this page.]

Exact Legal Name: Advocate Health and Hospitals Corporation d/b/a Advocate Christ Medical Center		
Address: 4440 W. 95 th Street, Oak Lawn, IL 60453		
☒ Non-profit Corporation	☐ Partnership	
☐ For-profit Corporation	☐ Governmental	
☐ Limited Liability Company	☐ Sole Proprietorship	☐ Other
- o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. - o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. - o Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.		
APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.		

Organizational Relationships

Provide (for each co-applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

APPEND DOCUMENTATION AS ATTACHMENT-4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at www.FEMA.gov or www.illinoisfloodmaps.org. **This map must be in a readable format.** In addition please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2005-5 (<http://www.hfsrb.illinois.gov>).

APPEND DOCUMENTATION AS ATTACHMENT -5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT-6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT**1. Project Classification**

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

Part 1110 Classification:

- ☐ Substantive
- ☒ Non-substantive

2. Narrative Description

Provide in the space below, a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

Advocate Health and Hospitals Corporation d/b/a/ Advocate Christ Medical Center and Advocate Health Care Network, the applicants, are seeking a permit to expand and modernize several clinical service areas including the Adult and Pediatric Level I Trauma/Resuscitation Center (Trauma Center), the comprehensive Emergency Department, general radiology (to support the trauma and emergency areas), inpatient endoscopy, Phase I and Phase II recovery (to support cardiac catheterization and endoscopy) as well as triage, a cast room and transesophageal echo (TEE). The Medical Center's trauma and emergency services provide pediatric care for Advocate Children's Hospital – Oak Lawn as well as adult care for the Medical Center.

The applicants are seeking a permit to implement this third phase of the Medical Center's campus master plan that was initiated in early 2011. When the first phase of the master plan, the Ambulatory Pavilion, opened in March 2014, several services adjacent to the Trauma Center, the Emergency Department, and recovery stations were relocated to the Pavilion. This project (Project) proposes a multi-phase expansion and modernization of existing space and the space vacated by the relocations to the Ambulatory Pavilion.

The following expansion of clinical key rooms is being proposed as part of the Project:

	Current	Proposed
Level I Trauma/Resuscitation Rooms	8	12
Emergency Stations		
Adult ¹	26	52
Pediatric	16	18
Total	42	70
Endoscopy/GI Labs	3	3
General Radiology Units	--	2
Triage	4	5
Phase I Recovery	10	10
Phase II Recovery	9	21
Cast Room	1	1
TEE Room	1	1

¹ Current adult emergency station count does not include 18 curtained cubicles that are used by emergency patients.

The adult emergency area will include stations designed to meet the special needs of behavioral health and geriatric patients. The recovery rooms will support the Endoscopy Lab and the adjacent existing cardiac cath labs (that are not part of this Project).

Non clinical space including EMT support, education space, administrative space, public spaces, and building components will also be part of the Project.

A site plan showing the location of the Project on the Medical Center's campus is included as Narrative, Exhibit 1. Parking will remain as is with spaces across the street from the Emergency Department entrance drop off as well as additional parking in the new, nearby free parking structure, if needed. Additional parking for ambulances and other emergency vehicles will be created with the expansion and enhancement of the parking ramp which is used to access the trauma center (that is not part of this Project).

A Phasing Schedule of the proposed Project is included as Narrative, Exhibit 2.

The proposed Project will be developed in two major phases which include a total of 7 sub-phases. Phase I elements include infrastructure, Emergency Department administration, and staff support, new ambulance entrance, Trauma Center and Emergency Department clinical expansion, and ground floor intake, elevator, stairs and sub waiting. If the Project is approved by the HFSRB in January 2015, Phase I construction will begin in the second quarter of 2015 and will be completed at the end of the third quarter of 2016. Phase II construction will begin in the second quarter of 2017 and will be completed at the end of the first quarter of 2020. Elements in Phase II include Phase I and Phase II recovery expansion, additional Emergency Department expansion and renovation, modernization of imaging space and installation of equipment. To allow for IDPH inspections and other post construction final reports, Project completion is expected to be December 31, 2020.

Several factors contribute to the duration of the project. For example, the staging of construction is very complex. It must ensure that existing operations are maintained; this will require multiple "checkerboard" moves. Strict requirements for fire safety, infection control and acoustical control during each phase of construction will require extensive interim safety measures undertaken with each phase including temporary barriers to protect patients and staff from the construction areas. Further, it will also be necessary to maintain internal circulation paths between the existing trauma and emergency areas to the inpatient bed tower elevators and the Imaging Department. The proximity of the project to other critical functions within the hospital will necessitate keeping adjacent hospital functions in operation. Further, several existing IT and

electrical closets will need to be relocated. As such, redundant IT and electrical closets will be required to ensure existing hospital low voltage systems and power remains operational in order to ensure the functionality of adjacent hospital modalities.

In letters dated August 6, 2014, Ms. Courtney Avery, Administrator of the Health Facilities and Services Review Board, advised Advocate Health and Hospitals Corporation that the electrical infrastructure system upgrades on the campus and the modernization of the ramp to the Level I Trauma Center intake area would not require certificates of need. The electrical infrastructure upgrades will begin in the second quarter of 2015 and be completed by the end of the first quarter of 2016. The ramp reconstruction will also begin in the second quarter of 2015 and will be completed by the end of the second quarter of 2016.

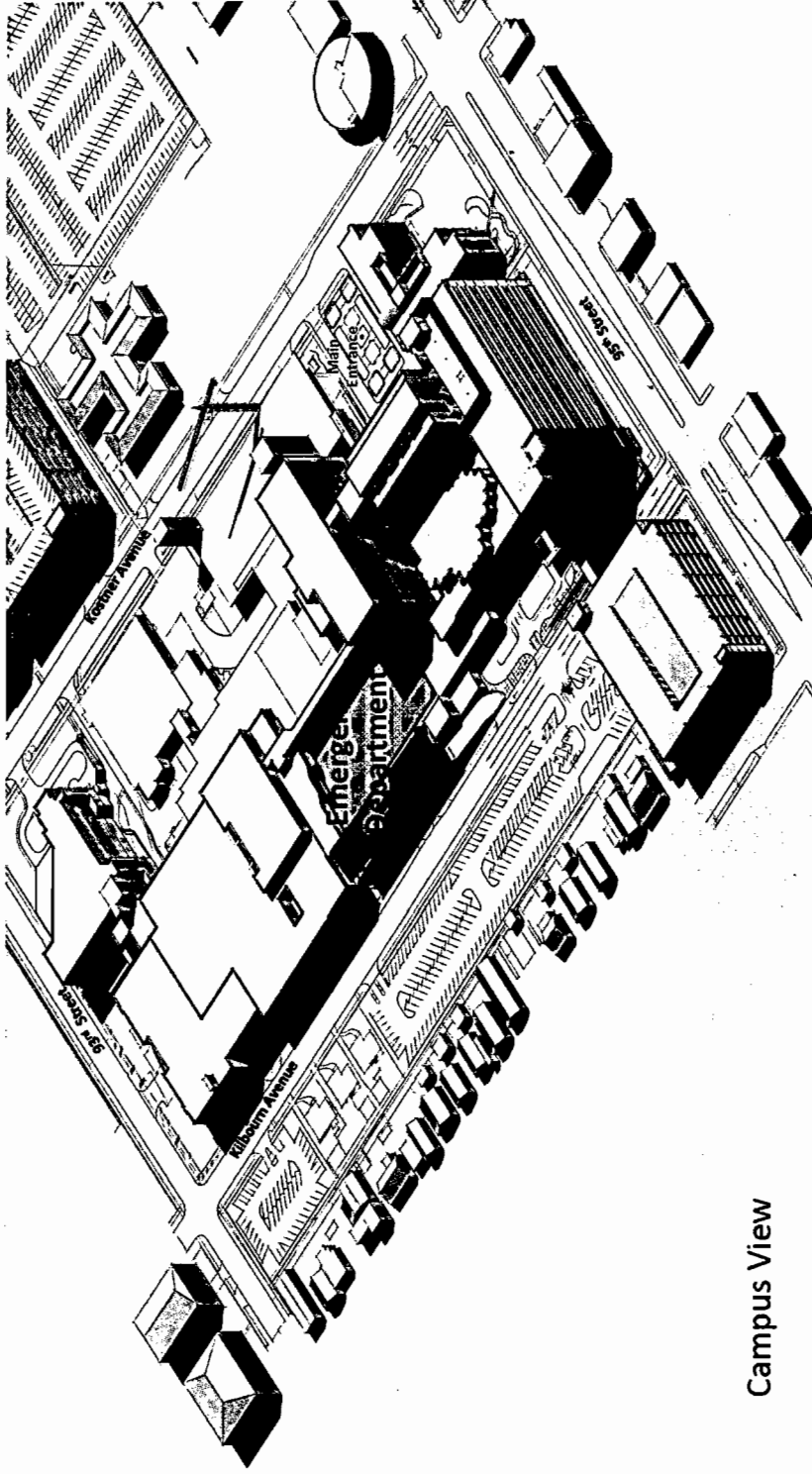
A stacking diagram of the proposed new construction and modernization is included as Narrative, Exhibit 3.

Total Project cost is estimated to be \$85,519,082; the project will be financed with cash and securities and debt.

The Project will include 8,835 square feet of new construction of which 1,447 square feet will be clinical and 7,388 square will be non clinical. The Project will also include 69,513 square feet of modernization of which 58,852 square feet will be clinical and 10,661 square feet will be non clinical.

Community support for the Project is documented in support letters included as Narrative, Exhibit 4.

In accordance with Public Act 96-31, the Project is classified as non substantive because it does not include a new facility, does not add or discontinue a service or propose a change in capacity of more than 20 beds.



Phasing Schedule – Level I Trauma Center / Emergency Department Expansion

CON Phases	2014		2015		2016		2017		2018		2019		2020			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
CON Application Process																
CON Submittal (10/27/14)																
CON Hearing (1/27/15)																
Completion Date (12/31/20)																
Phase 1 Total Timeline - Includes Design & Construction																
Design																
Infrastructure Design (Non-CON) ¹																
Construction																
Infrastructure Build (Non-CON) [2/1/16 completion date] ¹																
Phase 1a - ED Admin Build																
Phase 1b - Staff Support and New Ambulance Entrance (Future Peds) Build																
Phase 1c - ED Clinical Expansion (Future Peds) Build [6/1/16]																
Phase 1d ED First Floor Elevator, Stair and Waiting Build																
Phase 1d - ED Ground Floor Intake/First Floor Elevator, Stairs and Sub-waiting Build [8/1/16]																
Phase 2 Total Timeline - Includes Design & Construction																
Design																
Cath Prep-Rec/GI Design/ED Expansion Design																
Construction																
Phase 2a - Cath & GI Prep/Rec and GI																
Phase 2b - ED Expansion (Exist Prep/Rec & GI)																
Phase 2c - ED Expansion (Existing Peds ED)																
Phase 2d - ED Renovation/Imaging																
New Ramp Design Total Timeline ¹																
New Ramp Design (Non-CON)																
New Ramp Build (Non-CON) ¹																
¹ In letters dated August 6, 2014, Ms. Courtney Avery, Administrator, Health Facilities Services Review Board advised Advocate Health and Hospitals Corporation that the electrical system campus upgrades and ramp construction did not require an application for a certificate of need.																

C.O.N. STACKING DIAGRAM

DATE :October 17, 2014



Support Letters

State Senators

Bill Cunningham (18th District)

Jacqueline Y. Collins (16th District)

Christine Radogno (41st District – State Republican Leader)

State Representatives

Kelly Burke (36th District)

Monique D. Davis (27th District)

Frances Ann Hurley (35th District)

Renee Kosel (37th District)

Al Riley (38th District)

Mayors

Edward J. Zabrocki (Tinley Park)

Harry J. Klein (Burbank)

James J. Sexton (Evergreen Park)

Patrick E. Kitching (Alsip)

Kevin M. Casey (Hometown)

Village Clerk

Jane M. Quinlan (Oak Lawn)

Chief of Police

Robert D. Pyznarski (Chicago Ridge)

Steven Neubauer (Tinley Park)

Alan T. Vodicka (Hickory Hills)

Fire Chief

Thomas Styczynski (Alsip)

Advocate Christ Medical Center

James C. Doherty, MD MPH FACS, Director of Trauma Surgery

Sean E. Motzny, MD, Medical Director – Emergency Medical Services

Sue Hecht, BSN RN TNS IPEM CHEC-III, EMS Manager/EMS Administrative Director

CAPITOL OFFICE:
ROOM M118 STATE CAPITOL
SPRINGFIELD, ILLINOIS 62706
PHONE: 217/782-8146



DISTRICT OFFICES:
10400 SOUTH WESTERN AVE.
CHICAGO, ILLINOIS 60643
PHONE: 773/448-8128
FAX: 773/672-5143

16033 SOUTH 94TH AVE.
ORLAND HILLS, ILLINOIS 60487
PHONE: 708/233-9703

ILLINOIS STATE SENATE
BILL CUNNINGHAM
STATE SENATOR - 18TH DISTRICT
WWW.SENATORBILLCUNNINGHAM.COM

Courtney R. Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, IL 62761

Dear Ms. Avery:

As the state senator for the community and as a life-long resident of the area, I am writing to express my support for Advocate Christ Medical Center's application to expand the size of its emergency department in its Oak Lawn complex.

Not only is Advocate Christ a vital institution in my district, it is also the only Level I trauma center for the South Side and South Suburbs of Chicago. As such, Advocate Christ provides emergency services to an expansive, highly populated geographic region that includes some of the Chicago area's most violent neighborhoods.

As other hospitals in the area have eliminated and scaled back emergency services, Advocate Christ has picked up the slack. Their facilities are being overwhelmed by the sheer volume of patients the emergency department treats. I personally witnessed the stress placed on their facilities recently when I had to bring a family member to Advocate Christ for an emergency. I saw several curtained hallway cubicles set up to provide patients privacy, medical staff crowded around overburdened work stations, and traffic jams slowing the movement of patients and equipment through the corridors. Despite these challenges, the staff provides excellent care. In fact, Advocate Christ has achieved an impressive 97 percent "save" rate in the emergency department.

Advocate Christ Medical Center and Advocate Children's Hospital in Oak Lawn have consistently demonstrated an ongoing commitment to health ministry and public service in my community. They care for all patients, regardless of race, income status, language comprehension, and ability to pay. Their proposed expansion of the emergency department will enable them to better meet this mission of public service and allow them to continue as the most important healthcare provider in my district and one of the most vital health centers in the entire state of Illinois. I urge the Health Facilities and Services Review Board to approve Advocate Christ's request for the expansion of its emergency department.

Sincerely,

A handwritten signature of Bill Cunningham in black ink.

Bill Cunningham
State Senator, 18th Dist.

RECYCLED PAPER • SOYBEAN INKS



ILLINOIS STATE SENATE

☐ CAPITOL OFFICE:

M 114 STATE CAPITOL
SPRINGFIELD, ILLINOIS 62706
(217) 782-1607
FAX: (217) 782-2115

☒ DISTRICT OFFICE:

1155 WEST 79TH STREET
CHICAGO, ILLINOIS 60620
(773) 224-2830
FAX: (773) 224-2855



Jacqueline Y. Collins
STATE SENATOR • 16TH DISTRICT

COMMITTEES:

- FINANCIAL INSTITUTIONS
CHAIRPERSON
- INSURANCE
VICE CHAIR
- ENERGY
- TRANSPORTATION

August 25, 2014

Courtney R. Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

Dear Ms. Avery:

I enthusiastically write this letter in support of Advocate Christ Medical Center's plans to increase the size of its emergency department on its Oak Lawn campus. As the Senator for the 16th District, I recognize the vital needs that this expansion would provide for the Southland and Chicago's South and Southeast sides.

It is my understanding that this expansion will improve patient access to emergency services, enhance patient privacy and speed the emergency department's care of patients who are 65 years and older. Expanding the emergency department would allow Advocate Christ Medical to continue providing high quality care to all – insured and uninsured, who find themselves in the vulnerable position of critical health challenges.

Advocate's track record is stellar and is deserving of such an expansion. They have an incredible "save" rate of 97 percent! Also, the medical center is a coordinating hospital for a seven-county region in times of disaster.

Again, I support Advocate's request for an expansion of its emergency department. Advocate Christ Medical Center and Advocate Children's Hospital-Oak Lawn has been committed to health care excellence throughout the region for everyone – insured and uninsured. As servant leaders of the residents whom I represent, Advocate's top-level service depends on its ability to meet the growing, emergent needs. Please do not hesitate calling me for further discussion.

Sincerely,

Jacqueline Y. Collins
State Senator, 16th District

RECYCLED PAPER • SOYBEAN INKS

DISTRICT OFFICE:
1011 STATE ST., SUITE 210
LEMONT, IL 60439
(630) 243-0800
FAX: (630) 243-0808



CAPITOL OFFICE:
309G STATE HOUSE
SPRINGFIELD, IL 62706
(217) 782-9407
FAX: (217) 782-7818

CHRISTINE RADOGNO
SENATE REPUBLICAN LEADER • 41ST DISTRICT

August 8, 2014

Courtney R. Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

Dear Ms. Avery:

As the senator for Illinois District 41, I support plans by Advocate Christ Medical Center to increase the size of its emergency department on its Oak Lawn campus.

The medical center serves as the only Level I trauma center for the Southland and Chicago's South and Southeast sides, providing 24-7 care to the most critically injured patients and achieving an incredible "save" rate of 97 percent. The medical center also is a coordinating hospital for a seven-county region in times of disaster. The residents whom I represent depend on it remaining a top-level facility that is able to meet the growing, emergent needs of communities in our region.

Advocate Christ Medical Center and Advocate Children's Hospital-Oak Lawn continually demonstrate a commitment to a health ministry that cares for all residents in need throughout the region, regardless of their race, income status, language comprehension and ability to pay. The proposed expansion of the emergency department will further ensure that all patients can continue receiving the highest quality care when they seek it and when they absolutely need it.

In accordance with the ethical principles outlined in Part 2 of the Illinois Governmental Ethics Act, I have evaluated this project and in determining that it will serve the interest of the citizens of the 41st Legislative District, I urge members of the Illinois Health Facilities and Services Review Board to approve the institution's Certificate of Need request for an expansion of its emergency department.

Sincerely,

A handwritten signature in cursive script that reads "Christine Radogno".

Christine Radogno
State Senator, 41st District
Illinois Senate Republican Leader

RECYCLED PAPER • SOYBEAN INKS

ILLINOIS HOUSE OF REPRESENTATIVES



District Office
5144 W. 95th Street
Oak Lawn, IL 60453
708.425.0571
708.425.0642 fax

Kelly Burke
State Representative
36th District

Capitol Office
266-S Stratton Office Building
Springfield, IL 62706
217.782.0515
217.558.3741 fax

August 19, 2014

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities Planning and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, IL 62761

Dear Ms. Avery:

I am writing in strong support of Advocate Christ Medical Center's application for a Certificate of Need for its proposed emergency department project.

Christ Hospital is the leading teaching hospital in the southwest area of Cook County. It is also the only Level 1 trauma center for the south side of Chicago, south and southwestern Cook County and Will County. The trauma center receives patients as far away as Lake County, Indiana. It is crucial that Advocate Christ Medical Center be able to adequately serve and assist those who need it. The emergency department is woefully undersized for the number and acuity of the patients it serves.

As a member of the Illinois House of Representatives Emergency Medical Services Task Force, I have developed a keen appreciation for the role that emergency departments play in ensuring that the ill and the injured are treated with the highest possible standards. In addition, the area that Advocate Christ Medical Center serves includes areas where residents are exposed to higher than average amounts of violent crime. Advocate Christ Medical Center is often the place where victims of those crimes, especially gun violence, are treated.

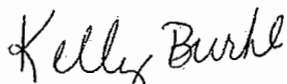
RECYCLED PAPER • SOYBEAN INKS

The Advocate Christ Medical Center Emergency Department doctors, nurses and staff work tirelessly and have extensive training and education, but their ability to provide the best possible care is limited by the space they currently have. The proposed expansion project would nearly triple the size of the current facility, creating much needed space for adults and children, increase the capacity of the trauma center, and provide modern, up-to-date amenities and technology. In addition, the enlarged space would allow staff to carve out treatment area for behavioral and mental health patients and for elderly patients.

I hope that the review board will carefully consider Advocate Christ Medical Center's application and grant approval for the expansion of the emergency department.

Please feel free to contact me if I can offer any further information.

Sincerely,


Kelly Burke

DISTRICT OFFICES
10400 S. WESTERN AVE.
CHICAGO, IL 60643
(773) 445-8128
(773) 672-5144 FAX

16033 S. 94TH AVE.
ORLAND HILLS, IL 60487
(708) 233-9703

SPRINGFIELD OFFICE
252-W STRATTON BUILDING
SPRINGFIELD, IL 62706
(217) 782-8200
EMAIL: repfranhurley@gmail.com



STATE OF ILLINOIS
FRANCES ANN HURLEY
STATE REPRESENTATIVE
35TH DISTRICT

COMMITTEES
• APPROPRIATIONS
GENERAL SERVICE
• CITIES & VILLAGES
• HEALTH CARE LICENSES
• PUBLIC SAFETY:
POLICE & FIRE
• TRANSPORTATION:
REGULATION, ROADS &
BRIDGES

August 11, 2014

Courtney R. Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

Dear Ms. Avery:

As the state representative for Illinois District 35, I wholeheartedly support plans by Advocate Christ Medical Center to increase the size of its emergency department on its Oak Lawn campus. This proposal responds to the hospital's critical need to increase its emergency capacity. The medical center serves as the only Level I trauma center for the Southland and Chicago's South and Southeast sides, providing 24-7 care to the most critically injured patients and achieving an incredible "save" rate of 97 percent. The medical center also is a coordinating hospital for a seven-county region in times of disaster. The residents whom I represent depend on it remaining a top-level facility that is able to meet the growing, emergent needs of communities in our region.

Expansion of the emergency department's physical space will improve patient access to emergency services at Christ Medical Center main campus, help reduce the number of hours in which it has to be on bypass, enhance patient privacy by eliminating reliance on curtained hallway cubicles and provide space that can be segregated to address the special needs of specific patient populations, including geriatric patients. Recently, the medical center developed a geriatric track program -- one of only several dozen in the United States -- to speed the emergency department's care of patients who are 65 years or older and to address their specific health needs.

I applaud Advocate Christ Medical Center and Advocate Children's Hospital-Oak Lawn for their ongoing commitment to a health ministry that cares for all residents in need throughout the region, regardless of their race, income status, language comprehension and ability to pay. The proposed expansion of the emergency department is simply a demonstration of that commitment as the medical center works to ensure that all patients can continue receiving the highest quality care when they seek it and when they absolutely need it. I urge members of the Illinois Health Facilities and Services Review Board to approve the institution's Certificate of Need request for an expansion of its emergency department.

Sincerely,

A handwritten signature in black ink, appearing to read "Frances A. Hurley".
Frances A. Hurley
State Representative, 35th District

RECYCLED PAPER • SOYBEAN INKS



Renée Kosel
State Representative

Springfield Office: Stratton Office Building Springfield, Illinois 62706 217.782.0424 217.557.7249 fax

August 18th, 2014

Courtney R. Avery,
Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Avery,

As Illinois State Representative for the 37th District, I strongly support Advocate Christ Medical Center's plan to increase the size of its emergency department by remodeling and using the interior of a recently vacated space on their Oak Lawn hospital campus. The hospital's emergency room has seen explosive growth over the last 20 years, and can no longer serve the large number of patients it receives on a daily basis in its current location. Christ serves as the only Level I trauma center for Chicago's south side, east side, and south suburbs. The medical center also is a coordinating hospital for the seven-county region during disasters. Many of the residents I represent depend on it remaining a top-level facility that is able to meet the growing needs of our area.

As Vice-Chair of the Governing Council of Christ Hospital, I am well aware of the challenges faced by the medical center's emergency department. These challenges include patient overcrowding, reduced levels of patient privacy, and a "one size fits all" approach to treating patients of varying demographics. Moving the medical center's emergency department would solve these issues by nearly tripling the medical center's current facility, adding up-to-date amenities and technology like specially equipped resuscitation rooms for trauma patients, and equipment to properly treat each patient individually, including seniors and persons with behavioral and mental health disorders.

Advocate Christ Medical Center continues to provide care for all residents in need throughout the region, regardless of their race, income status, language comprehension, or ability to pay. The expansion of their emergency department would ensure that all area patients can continue receiving the highest quality care available from this wonderful hospital. I urge members of the Illinois Health Facilities and Services Review Board to approve the institution's Certificate of Need for expansion of their emergency department.

District Office: 19201 S. LaGrange Road, Suite 204B, Mokena, Illinois 60448 708.479.4200 708.479.7977 fax

If I can provide any further information about this important matter, please contact my district office at 708-479-4200. Thank you for your consideration of this important regional need.

Sincerely,

A handwritten signature in cursive script, appearing to read "Renee Kosel".

Renee Kosel
State Representative

<i>Springfield Office:</i>	<i>Stratton Office Building</i>	<i>Springfield, Illinois 62706</i>	<i>217.782.0424</i>	<i>217.557.7249 fax</i>
<i>District Office:</i>	<i>19201 S. LaGrange Road, Suite 204B,</i>	<i>Mokena, Illinois 60448</i>	<i>708.479.4200</i>	<i>708.479.7977 fax</i>

DISTRICT OFFICE:
3649 W. 183RD STREET
SUITE 102
HAZEL CREST, ILLINOIS 60429
708/799-4364

CAPITOL OFFICE:
262 - W STRATTON BUILDING
SPRINGFIELD, ILLINOIS 62708
217/558-1007



AL RILEY
STATE REPRESENTATIVE - 38TH DISTRICT
ASSISTANT MAJORITY LEADER

COMMITTEES:
• APPROPRIATIONS
• GENERAL SERVICE
• CITIES & VILLAGES
• COUNTIES & TOWNSHIPS
• MASS TRANSIT
• COMMISSION ON
GOVERNMENT FORECASTING
& ACCOUNTABILITY

August 25, 2014

Courtney R. Avery, Administrator
Illinois Health Planning Facilities Board
525 West Jefferson, Second Floor
Springfield, Illinois 62761

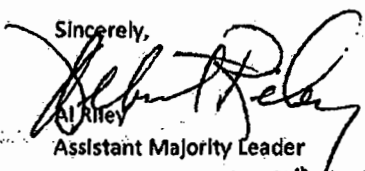
Dear Ms. Avery:

I am writing this letter to indicate my strong support of Advocate Christ Medical Center's ambitious and vital expansion of their adult and pediatric emergency facilities. I therefore support and endorse their Certificate of Need (CON) application. This project addresses perhaps some of the most critical emergency services needs in this state. Just speaking for a portion of my district, the diminution of emergency and Level 1 trauma services in the south suburbs has been a major concern for our region. The issue comes up at almost every community forum that I participate in. It is critical that ACMC be able to expand emergency services to better address the needs of a growing regional population.

Not only is the proposed project vital, its construction will be efficiently carried out. ACMC will adaptively reuse space which became free after their Outpatient Pavilion was completed earlier in the year. Of course, there will be the ancillary positive economic benefit in the area emanating from job opportunities, supply and equipment purchases, construction work and support to local businesses during the project.

Again, I fully support AAMC's efforts to address the health care needs of their large catchment area. I would urge the members of the Illinois Health Facilities Planning Board to approve the Certificate of Need request for their emergency services expansion.

Sincerely,


Al Riley
Assistant Majority Leader
State Representative, 38th District

RECYCLED PAPER • SOYBEAN INKS



Tinley Park

ILLINOIS

August 11, 2014

Village President
Edward J. Zabrocki

Village Clerk
Patrick E. Rea

Village Trustees
David G. Seaman
Gregory J. Hannon
Brian S. Maher
Thomas J. Staunton, Jr.
Patricia A. Leonl
T. J. Grady

Village Hall
16250 S. Oak Park Ave.
Tinley Park, IL 60477

Administration
(708) 444-5000
Fax: (708) 444-5099

Building & Planning
(708) 444-5100
Fax: (708) 444-5199

Public Works
(708) 444-5500

Police Department
7850 W. 183rd St.
Tinley Park, IL 60477

(708) 444-5300/Non-emergency
Fax: (708) 444-5399

John T. Dunn
Public Safety Building
17355 S. 68th Court
Tinley Park, IL 60477

Fire Department & Prevention
(708) 444-5200/Non-emergency
Fax: (708) 444-5299

BMA
(708) 444-5600
Fax: (708) 444-5699

Senior Community Center
(708) 444-5150

www.tinleypark.org



Ms. Courtney R. Avery, Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

Dear Ms. Avery:

As Mayor of the Village of Tinley Park, I fully support Advocate Christ Medical Center's application to expand its emergency department. Elected officials in this community and my entire administrative team are acutely aware that the medical center frequently reaches critical capacity in its ER and desperately requires room to grow. Failure to permit development of increased space will have a negative impact on the institution's ability to continue delivering the highest quality emergency care to the residents of my community.

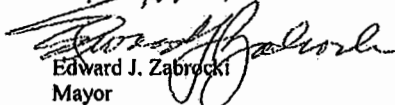
We are also acutely aware of the medical center's service as the only Level I trauma center serving the Southland and as a coordinating hospital for a seven-county region during times of disaster. At the same time, the emergency department is a primary gateway into Christ Medical Center, which recently was rated number three overall among hospitals in Illinois by *U.S. News & World Report*. When the medical center must go on bypass, patients from our area in need of emergency care are diverted to other hospitals, oftentimes located a much greater distance from their homes and families. Anything that can be done to support Christ Medical Center's role in providing emergency and trauma services in this community is wholeheartedly favored by my office.

Particularly important is Christ Medical Center's economic role in the Southland. A recent report, issued by the Metropolitan Chicago Healthcare Council, indicated that the medical center generates an estimated \$900,000,000 in community economic activity annually as the dollars earned by medical center associates are spent on groceries, clothing, mortgage payments, rent and other expenses. The medical center also supports the economy through the purchase of goods and services and capital spending. This level of activity, according to the report, has resulted in the creation of literally thousands of new jobs in the region.

Approval of the proposed emergency department expansion will create much needed, modernized space for both adult and pediatric care. My understanding is that, to achieve this expansion, the medical center intends to use nearby, internal space that was vacated in the main hospital building when other clinical services relocated to the campus' new Outpatient Pavilion, which opened at the end of March of this year. External construction work will be minimal.

I urge the planning board to approve the emergency department plans as presented by Advocate Christ Medical Center. The project is critical to the future of the medical center, the health care needs of patients in the region and the ongoing economic growth of the south and southwest suburbs of Chicago.

Respectfully yours,


Edward J. Zabrocki
Mayor



Office of the Mayor
6530 West 79th Street
Burbank, IL 60459-1198
(708) 599-5500

Harry J. Klein
Mayor

August 12, 2014

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, IL 62761

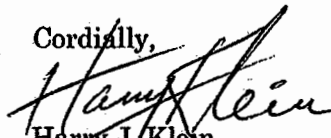
Dear Ms. Avery:

As Mayor of the City of Burbank, I fully support Advocate Christ Medical Center's application to expand its emergency department. Elected officials in our community and my entire administrative team are acutely aware that the medical center frequently reaches critical capacity in its emergency room. Failure to permit development of increased space will have a negative impact on the institution's ability to continue delivering the highest quality emergency care to the residents of my community.

Recently, one of Burbank's aldermen suffered a heart attack and was successfully brought back from the brink of death by Christ Hospital's emergency personnel. Allowing Christ Hospital to expand its emergency facilities would go a long way in saving countless other patients, like him.

I feel it to be a no-brainer to allow Christ Hospital to be approved for expansion of its emergency department to further serve my community and those in the southwest suburban area.

Cordially,


Harry J. Klein
Mayor



printed on recyclable paper



Village of Evergreen Park

Mayor
James J. Sexton

9418 SOUTH KEDZIE AVENUE
EVERGREEN PARK, ILLINOIS 60805
Tel. (708) 422-1551
Fax (708) 422-7818

Courtney R. Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, IL 62761

Dear Ms. Avery:

I am writing this letter on behalf of Advocate Christ Medical Center's application to expand its emergency department.

Since the Medical Center is the only Level I trauma center for the south/southeast sides of Chicago, south/southwestern Cook County, all of Will County and other regions of these areas reaching far south and west and medical trauma cases on the rise, the Center is often on bypass and unable to accommodate these trauma patients. Sending them further away from their loved ones makes both travelling distance and precious lifesaving moments often impossible.

With 95,000 emergency patients annually and a facility that was built for half that amount of patients, the need for expansion is crucial. Advocate Christ Medical Center Emergency Department is currently undersized as far as physical space for accommodating trauma patients, regular emergency room patients, and as a training center for Emergency Medical Technicians.

This new expansion project would provide much needed space and will allow for the highest quality medical care for the residents of this community as well as the surrounding communities. It will provide less wait time and more privacy for emergency department patients, increase the capacity for trauma patients who may otherwise be sent to medical centers further away, allow for specific treatment areas for unique patient needs such as pediatric and geriatric patients, and upgrade to a covered parking garage to accommodate more emergency vehicles, patient drop off/arrivals and emergency department parking for cars.

Please accept this letter as my full support of the Advocate Christ Medical Center Proposed Emergency Department Project.

Sincerely,

James J. Sexton, Mayor
Village of Evergreen Park



Patrick E. Kitching
Mayor
Deborah L. Venhuizen
Clerk and Collector



Trustees
John R. Shapiro
Sheila B. McGreal
Richard S. Dalzell
John D. Ryan
Kevin P. Michaels
Lynn M. Dwyer

August 22, 2014

Courtney R. Avery
Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Ms. Avery,

Because Advocate Christ Medical Center and Advocate Children's Hospital in Oak Lawn are planning to renovate and expand their emergency departments I want to convey to you my complete support in this project.

Being a retired firefighter/medic and now the Mayor of Alsip I know how crucial it is to meet the needs of the community. I know firsthand that on several occasions a month, usually on weekends and holiday's the Hospital goes on "bypass" because it cannot handle the current demands of the area. Since it is a Level 1 trauma center for the entire southern portion of Cook County it is necessary for them to expand to help meet the needs of the most critical medical cases. Since the facilities are over 20 years old, it would only make sense that they should modernize and expand space to meet the needs of the ever growing demand for their services. Unfortunately, the area has a high demand for a trauma center which is why I fully support their attempt to secure state approval and move forward with the emergency department expansion project.

Should you have any questions feel free to contact me at my office, 708-385-6902 Ext. 317. I look forward to hearing that they were successful in their application process.

Sincerely,

Patrick E. Kitching
Mayor

4500 West 123rd Street • Alsip, Illinois 60803-2599 • Phone 708-385-6902 • Fax 708-385-9561

ALDERMEN**Ward One**

Donna Grochowski
Salvatore A. Roti

Ward Two

Brian Barnhouse
Rick Banasiak

Ward Three

Spencer A. Touchie
Gary Scheckel

Ward Four

Daniel J. Walsh
Howard Reinheimer

Ward Five

Gary Byrne
Thomas R. Carmody

**CITY OF HOMETOWN**

4331 SOUTHWEST HIGHWAY
HOMETOWN, ILLINOIS 60456
(708) 424-7500
FAX (708) 424-7589

MAYOR

Kevin M. Casey

CITY CLERK

Mary Jo C. Hacker

CITY TREASURER

Michael A. Madden

CITY ATTORNEY

Louis F. Cainkar

Courtney R. Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jackson Street 2nd Floor
Springfield, IL 62761

August 25, 2014

Dear Ms. Avery,

I come to you today to ask that you please consider granting Advocate Christ Medical Center the go ahead to expand their emergency room. I have lived within a 2 minute drive from this facility my whole life, I am 58 years old. I am the Mayor of Hometown where I have lived my whole life. I have watched this facility go from a 5 story community hospital to a major medical facility level one trauma center. I have seen the increased ambulance traffic going to this facility from every direction. Along with that has also come the reality of many local residents avoiding this fantastic facility in their backyard due to the long waits and unavailable beds. I have seen much too often the ER be put on adult bypass and our ambulance have to take residents to alternate facilities for this reason.

This facility serves such a large population that there is no way they can continue with the limited space provided. I have personally known people that went to the ER and spent days, not hours days in the hallway because the treatment rooms were full. I have personally been in a curtained area awaiting treatment with a mental health patient on the other side of the curtain. All this did was add to an already stressful situation for myself and my family. This patient ended up needing restraints and was extremely agitated and my stress level went through the roof. I have witnessed and heard things that are grossly against HIPA but with no privacy allowed most ER patients at this facility in its present state, this will continue to happen.

I urge you to please approve this request and help move this ER into a respectful, modern facility that can care for its patients as an ER is meant to, with dignity and the utmost respect for privacy. Allow patients from near as well as far come to this facility and receive a space to be examined behind closed doors, allow geriatric patients to not be fearful of other patients and allow those with special needs to have those needs attended to in a private manner.

Thank you for taking the time to read my thoughts on this matter and if you should have any questions please feel free to contact me.

Kevin M. Casey
Mayor
City of Hometown
4331 Southwest Highway
Hometown, IL 60456
708-424-7500
kncasey54@hotmail.com



9446 SOUTH RAYMOND AVENUE, OAK LAWN, ILLINOIS 60453
TELEPHONE: (708) 636-4400 | FACSIMILE: (708) 636-8606 | WWW.OAKLAWN-IL.GOV

August 6, 2014

Courtney R. Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, IL 62761

Dear Ms. Avery:

I am writing this letter in support of Advocate Christ Medical Center and Advocate Children's Hospital in Oak Lawn, as they are planning to renovate and expand their emergency departments. As I witness daily, there is a growing need for emergency services at the hospital. With Advocate serving as a Level I trauma center for all of southern, southeastern and southwestern Cook County, as well as all of Will County and Northwest Indiana, they are the regional health care coordinating hospital during disasters for a seven-county area; trains more than 2,500 emergency medical technicians, paramedics and other providers of emergency care annually.

With Advocate Christ Medical Center and Advocate Children's Hospital being our largest employer in the Village of Oak Lawn, I do work closely with the hospital. We are proud to have them in our community and I do see the professional day to day operations of the facilities. I feel the renovation and expansion are critical to serve the needs as a Level I trauma center.

Advocate Christ Medical Center and Advocate Children's Hospital is an asset to the Village of Oak Lawn in many aspects. From my own personal experiences at the hospital, I always know I am in good hands with their tremendous care.

Thank you for your time and if you have any questions, please feel free to contact me at jquinlan@oaklawn-il.gov.

Sincerely,

Jane M. Quinlan, CMC
Oak Lawn Village Clerk

DR. SANDRA BURY
VILLAGE PRESIDENT

JANE M. QUINLAN, CMC
VILLAGE CLERK

LARRY R. DEETJEN, CM
VILLAGE MANAGER

VILLAGE TRUSTEES
MIKE CARBERRY
TIM DESMOND
ALEX G. OLEJNICZAK
CAROL R. QUINLAN
ROBERT J. STREIT
TERRY VORDERER



VILLAGE OF CHICAGO RIDGE

POLICE DEPARTMENT

10425 S. RIDGELAND AVENUE
CHICAGO RIDGE, ILLINOIS 60415



EMERGENCY 911
NON-EMERGENCY
708-425-7831

CHIEF ROBERT D. PYZNARSKI

FAX
708-857-4460

Courtney R. Avery
Administrator
Illinois Health Facilities and Service Review Board
525 W. Jefferson St., 2nd Floor
Springfield, Illinois 62761

Ms. Avery,

In light of information we received regarding Advocate Christ Medical Center's desire to expand the emergency room capabilities, I am writing this letter to state our support for the expansion of the facility.

In our line of work, we are well aware of the need for sufficient emergency medical services and the space with which to provide those services to our local community and quite far beyond. Advocate Christ Medical Center serves as a Level I Trauma center to a large geographical area, even including part of northern Indiana.

I support the expansion of the emergency services and facility to house them which will further ensure the well-being of our officers and community members should the need arise in an emergency situation.

Sincerely,

Robert D. Pyznarski
Chief of Police

RP/db



Village President
Edward J. Zabrocki

Village Clerk
Patrick E. Rea

Village Trustees
David G. Seaman
Gregory J. Hannon
Brian S. Maher
Thomas J. Staunton, Jr.
Patricia A. Leoni
T. J. Grady

Village Hall
16250 S. Oak Park Ave.
Tinley Park, IL 60477

Administration
(708) 444-5000
Fax: (708) 444-5099

Building & Planning
(708) 444-5100
Fax: (708) 444-5199

Public Works
(708) 444-5500

Police Department
7850 W. 183rd St.
Tinley Park, IL 60477
(708) 444-5300/Non-emergency
Fax: (708) 444-5399

John T. Dunn
Public Safety Building
17355 S. 68th Court
Tinley Park, IL 60477

Fire Department & Prevention
(708) 444-5200/Non-emergency
Fax: (708) 444-5299

BMA
(708) 444-5600
Fax: (708) 444-5699

Senior Community Center
(708) 444-5150

www.tinleypark.org



August 12, 2014

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities and Services
Review Board
525 West Jefferson Street
2nd Floor
Springfield, IL 62761

Dear Ms. Avery:

It is my pleasure, and I believe my responsibility, to write this letter in support of the proposal being submitted by Advocate Christ Medical Center for the renovation and expansion of its emergency room facilities. The current facility treats nearly twice the number of patients it was originally designed to accommodate, and the projected improvements will allow the hospital to remedy that situation.

As a chief of police, I am acutely aware of the need for emergency preparedness and disaster response; and Advocate Christ Medical Center, as a Level 1 trauma center and coordinating hospital for a seven-county area in times of disaster, is an integral part in that process. The planned upgrades in physical space, treatment rooms, technology, and accessibility will significantly enhance the hospital's available resources and enable it to appropriately respond not only in large-scale catastrophic events but at all levels of emergency care.

In the interests of all those who rely on the life-saving services of Advocate Christ Medical Center, I fully support the hospital's efforts to provide a state-of-the-art emergency department; and I urge the Illinois Health Facilities and Services Board to approve its Certificate of Need request.

Sincerely,

Steven Neubauer
Chief of Police

acg

City of Hickory Hills Police Department

8800 West 87th Street • Hickory Hills, Illinois 60457

Alan T. Vodicka
Chief of Police

Phone
(708) 598-4900

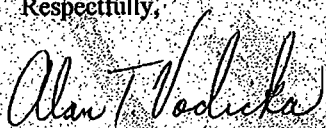
August 11, 2014

Courtney R. Avery
Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Avery,

I am writing this letter in support of Advocate Christ Medical Center's plan to expand its emergency department. As the leader of an agency that is responsible for emergency first response within the immediate vicinity of Christ Medical Center, I realize how important comprehensive Level I trauma services are to the community. During my thirteen year tenure as Chief of Police for the City of Hickory Hills I have witnessed firsthand the growth and changing demographics of our area. This growth and change has contributed to a constant strain upon these trauma services provided by Christ Medical Center. Therefore, I strongly support Christ medical Center's proposed expansion. If you would like additional information on this issue please feel free to contact me.

Respectfully,



Alsip Fire Department

12600 South Pulaski Avenue
Alsip, Illinois 60803

Station 1: (708) 385-6902 x233
Fax: (708) 371-6019

Station 2: (708) 385-6902 x234
Fax: (708) 489-9476



Thomas Styczynski
Chief x235

Robert Ricker
Deputy Chief x236

Fire Prevention Bureau
X237

August 7, 2014

Courtney R. Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

Dear Ms. Avery:

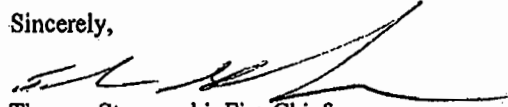
I am in favor of Advocate Christ Medical Center's plans to expand its emergency department and ask that the Illinois Health Facilities and Services Review Board approve the Certificate of Need so that the campus can move forward with the project.

Advocate Christ Medical Center serves as a critical role in our region as a nearby all-inclusive hospital to our residents, business employees, their customers and visitors to our area. Advocate Christ Medical Center is the only Level I trauma within a 20 mile area. It is also a coordinating hospital for a seven-county area in times of disaster. Any project that will allow it to maintain its status as a state-of-the-art, regional health center able to meet the needs of our growing and demographically changing communities should be supported.

My understanding is that the proposed expansion will enable more of our area residents to receive emergency care at Christ Medical Center when they need it rather than being diverted to other hospitals that are farther from their homes and are not always as equipped to provide the level of emergency services required. As Fire Chief for the Village of Alsip, I am simply amazed at the quality of care that physicians and nurses in the Christ Medical Center ER are able to deliver in such a constricted area. Allowing the medical center to expand will substantially increase the number of available treatment rooms overall, expand the trauma treatment area and provide specially equipped resuscitation rooms for trauma patients. The plan also will also create a covered garage to accommodate as many as 10 ambulances and other emergency vehicles at the same time to avoid waiting to access the Emergency Department or moving our residents into the Emergency Department without experiencing any of the outside elements.

For these reasons and for the sake of the Alsip residents as well as all of the residents and visitors in the Southland, I am hopeful that the state planning board will approve the medical center's request for its emergency department.

Sincerely,

A handwritten signature in black ink, appearing to read 'T. Styczynski', with a long horizontal flourish extending to the right.

Thomas Styczynski, Fire Chief



4440 West 95th Street || Chicago, IL 60453 || T 708.684.4248 || advocatehealth.com

August 18, 2014

To Whom It May Concern:

I am writing this letter to offer my support to the plan to expand the emergency department at Advocate Christ Medical Center over the next two years. Advocate Christ Medical Center (ACMC) is the busiest level I trauma center in the state of Illinois and also hosts one of the busiest emergency departments in the state. As a trauma center, ACMC serves as the primary site for the care of injured patients from Chicago's Southside, south suburban Cook County, and Lake County, Indiana. ACMC currently experiences over 100,000 emergency department visits per year, a volume far in excess of the 50,000 capacity for which it was originally designed.

Despite this significant size limitation, both trauma and general ED admission volumes have grown steadily over recent years without any compromise in patient care. In fact, at its last IDPH site survey, the ACMC trauma program was commended for its ability to perform high quality and high volume trauma care given the limited space provided in the current physical plant. Unfortunately, there is a limit to how much further increase in trauma volume ACMC can sustain before patient care would be compromised. The planned ACMC ED expansion would significantly increase the space provided for trauma care with twice as many dedicated trauma resuscitation rooms and a dedicated CT scanner directly adjoining the resuscitation area. In addition, both the adult and pediatric general emergency areas will be doubled in size. The ACMC ED expansion promises to dramatically improve the conditions under which the ACMC trauma service currently provides care and to provide the necessary infrastructure for future growth. Furthermore, the ED expansion at ACMC represents an essential component to the long term maintenance of quality trauma care in the region.

Sincerely,

James C. Doherty, MD MPH FACS

Director of Trauma Surgery and Critical Care programs, Advocate Christ Medical Center

Chair, Region VII Trauma Committee

A faith-based health system serving individuals, families and communities



Advocate Christ Medical Center

4440 West 95th Street || Oak Lawn, IL 60453 || T 708.684.8000 || advocatehealth.com

September 2, 2014

To Whom It May Concern:

I ask that the Illinois Health Facilities and Services Review Board strongly consider Advocate Christ Medical Center's plans to expand its emergency department. Advocate Christ Medical Center provides service for nearly 100,000 emergency and trauma patient visits annually and is the only Level I trauma center for south Chicago and the south and southwest suburbs of Cook and Will counties. Advocate Christ Medical Center services numerous EMS systems not just in the suburbs but also for the city of Chicago.

The current emergency department was designed to care for only 50,000 patients. This lack of appropriate size hinders the EMS systems because the medical center has been going on diversion/bypass for near record hours. This is not optimal care for the patients that we are attempting to serve. By nearly tripling the size of its emergency facilities as proposed, the medical center will be able to create more modern space that dramatically increases the likelihood that our area residents will be able to receive emergency care locally -- at a leading hospital -- when they need it rather than being diverted to other hospitals outside the region.

As an emergency medicine physician at Advocate Christ Medical Center, as well as the Medical Director of Emergency Medical Services, my primary concerns are for maintaining the health and vitality of the patients who come to our doors for care. The proposed expansion of our emergency department is an important and necessary step toward that goal.

Sincerely,

Sean E. Motzny, MD
Medical Director- Emergency Medical Services
Attending Physician
Advocate Christ Medical Center
Region VII EMS Advisory Council Standing Member

A faith-based health system serving individuals, families and communities

Recipient of the Magnet award for excellence in nursing services by the American Nurses Credentialing Center





Advocate Christ Medical Center

4440 West 95th Street || Oak Lawn, IL 60453 || T 708.684.8000 || advocatehealth.com

August 13, 2014

Courtney R. Avery
Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, 2nd Floor
Springfield, IL 62761

Dear Ms. Avery:

The need is urgent to expand the Advocate Christ Medical Center's (ACMC) Emergency Department (ED). Time after time, day after day, every single, imaginable, available space is used. The medical teams perform their jobs, caring for patients with conditions ranging from heart attacks, sprains and strokes, to multiple, critical injuries and all this work is done in extremely tight quarters with very little legroom. We are the only Level 1 trauma center in IDPH EMS Region VII. Patients, fire/police departments and multiple hospitals rely on us 24/7 to have the ability and space to provide tertiary care. The ED has definitely outgrown the current real-estate in which it is housed. A crucial upgrade to expand the ED is required to continue providing the outstanding care we give every day.

As the EMS manager, I can testify that many fire/police departments know where to bring the sickest patients – their choice, ACMC ED. During a disaster or major incident involving multiple, injured victims, we must have the ability to surge and accept many patients at one time. Our ED is functioning beyond full capacity on a day-to-day basis. We need additional space to handle disaster victims who will absolutely be sent our way at any given time or day.

For these reasons, I urge the Illinois Health Facilities and Services Review Board to approve Advocate Christ Medical Center's CON application to expand its ED.

Sincerely,


Sue Hecht, BSN, RN, TNS, IPFM, CHEC-III
EMS Manager/EMS Administrative Director
Center for Prehospital Care
Region VII RHCC Hospital
Disaster Preparedness Coordinator
Office: 708-684-3794
Sue.Hecht@advocatehealth.com

A faith-based health system serving individuals, families and communities

Recipient of the Magnet award for excellence in nursing services by the American Nurses Credentialing Center



Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must equal.

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	581,561	349,474	931,035
Site Survey and Soil Investigation	75,000	15,000	90,000
Site Preparation	1,495,447	356,461	1,851,908
Off Site Work	0	0	0
New Construction Contracts	570,821	2,643,324	3,214,145
Modernization Contracts	27,560,966	3,673,693	31,234,659
Contingencies	4,177,161	812,228	4,989,389
Architectural/Engineering Fees	2,529,790	558,220	3,088,010
Consulting and Other Fees	4,348,355	678,645	5,027,000
Movable or Other Equipment (not in construction contracts)	11,627,390	658,610	12,286,000
Bond Issuance Expense (project related)	574,533	126,117	700,650
Net Interest Expense During Construction (project related)	8,057,555	1,768,731	9,826,286
Fair Market Value of Leased Space or Equipment	0	0	0
Other Costs To Be Capitalized	10,638,400	1,641,600	12,280,000
Acquisition of Building or Other Property (excluding land)	0	0	0
TOTAL USES OF FUNDS	72,236,979	13,282,103	85,519,082
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	24,751,999	4,715,083	29,467,082
Pledges			0
Gifts and Bequests			0
Bond Issues (project related)	47,484,980	8,567,020	56,052,000
Mortgages			0
Leases (fair market value)			0
Governmental Appropriations			0
Grants			0
Other Funds and Sources			0
TOTAL SOURCES OF FUNDS	72,236,979	13,282,103	85,519,082
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project ☐ Yes ☒ No
Purchase Price: \$ _____
Fair Market Value: \$ _____

The project involves the establishment of a new facility or a new category of service
☐ Yes ☒ No

If yes, provide the dollar amount of all **non-capitalized** operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.

Estimated start-up costs and operating deficit cost is \$ Not Applicable.

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.

Indicate the stage of the project's architectural drawings:

☐ None or not applicable ☐ Preliminary
☒ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): December 31, 2020

Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):

- ☐ Purchase orders, leases or contracts pertaining to the project have been executed.
☐ Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies
☒ Project obligation will occur after permit issuance.

APPEND DOCUMENTATION AS ATTACHMENT-8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals

Are the following submittals up to date as applicable:

- ☒ Cancer Registry
☒ APORS
☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☒ All reports regarding outstanding permits

Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

Provide in the following format, the department/area **DGSF** or the building/area **BGSF** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							

APPEND DOCUMENTATION AS ATTACHMENT-9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Project Cost / Space Requirements							
Department	Project Cost	Gross Square Feet		Amount of Proposed Total GSF That Is:			
		Existing	Proposed	New Construction	Remodeled	As Is	Vacated Space ²
Reviewable / Clinical							
Trauma	\$ 8,791,241	1,432	7,342	0	7,342	0	1,432
Triage	\$ 1,762,582	726	1,447	1,447	0	0	726
Emergency Department Adult	\$ 27,233,341	14,984	22,737	0	22,737	0	14,984
Emergency Department Pediatric	\$ 15,964,372	6,097	13,324	0	13,324	0	6,097
Total Emergency Department	\$ 43,197,713	21,081	36,061		36,061		21,081
Phase 1 Recovery ¹	\$ 2,094,872	5,495	10,252	0	1,751	8,501	1,750
Phase 2 Recovery ¹	\$ 9,795,334		37,098	0	8,184	28,914	3,745
GI/Endoscopy	\$ 3,200,098	11,798	12,425	0	2,672	9,753	2,045
Cast Room	\$ 151,698	966	130	0	130	966	0
General Radiology	\$ 2,289,912	20,621	22,531	0	1,910	20,621	0
Ultra sound Mobile	\$ 657,357	14,060	14,614	0	554	14,060	0
TEE	\$ 296,172	191	248	0	248	0	191
Total Clinical	\$ 72,236,979	76,370	142,148	1,447	58,852	82,815	30,970
Non Clinical							
Admin	\$ 6,104,455	20,152	26,160	625	7,670	17,865	2,287
Public spaces	\$ 4,473,412	22,826	28,906	4,518	1,562	22,826	0
Building Components	\$ 2,704,236	343,846	345,698	445	1,429	342,024	1,822
Total Non-Clinical	\$ 13,282,103	386,824	400,764	7,388	10,661	382,715	4,109
Total Project	\$ 85,519,082	463,194	542,912	8,835	69,513	465,530	35,079

¹ Advocate Christ Medical Center's facility records have only one value for Phase I and Phase II Recovery square footage.

² Vacated space represents space vacated to accommodate another department or service that is part of the Project. At Project completion there will be no vacated space.

Facility Bed Capacity and Utilization

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert following this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which the data are available**. Include **observation days in the patient day totals for each bed service**. Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

FACILITY NAME: Advocate Christ Medical Center		CITY: Oak Lawn			
REPORTING PERIOD DATES: From: December 31, 2012 to: December 31, 2013					
Category of Service	Authorized Beds	Admissions	Patient Days ²	Bed Changes	Proposed Beds
Medical/Surgical	394	23,111	112,905		394
Obstetrics	56	4,467	12,205		56
Pediatrics	45	3,488	12,150		45
Intensive Care	153	5,507 ¹	32,869		153
Comprehensive Physical Rehabilitation	37	857	12,181		37
Acute/Chronic Mental Illness	39	1,208	8,454		39
Neonatal Intensive Care	64	1,003	9,589		64
General Long Term Care	0	0			0
Specialized Long Term Care	0	0			0
Long Term Acute Care	0	0			0
Dedicated Observation Other ((identify)	0	0			0
TOTALS:	788	39,641	200,353	0	788

¹ Direct Admissions Only

² Excludes observation days

Category of Service	Observation Days
Medical Surgical	2,473
Obstetrics	55
Pediatrics	1,192
Intensive Care	4
	3,724
Observation Days in	3,695
Dedicated Beds or Stations	7,419

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of Advocate Health and Hospitals Corporation
d/b/a Advocate Christ Medical Center *

in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

K. W. Lukhard
SIGNATURE

Kenneth W. Lukhard
PRINTED NAME

President
PRINTED TITLE

William Santulli
SIGNATURE

William Santulli
PRINTED NAME

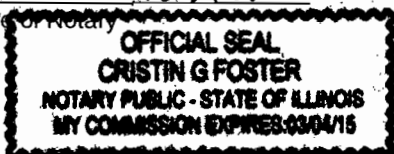
Executive Vice President, Chief Operating Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 16 day of October 2014

Cristin G. Foster

Signature of Notary

Seal



*Insert EXACT legal name of the applicant

Notarization:
Subscribed and sworn to before me
this 16 day of October 2014

Cristin G. Foster

Signature of Notary

Seal



CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- o in the case of a corporation, any two of its officers or members of its Board of Directors;
- o in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- o in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of Advocate Health Care Network * in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

JA Skogsberg
SIGNATURE

James H. Skogsbergh
PRINTED NAME

President and CEO

PRINTED TITLE

William Santulli
SIGNATURE

William Santulli
PRINTED NAME

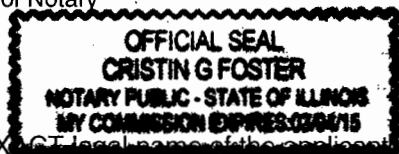
Executive Vice President, Chief Operating Officer

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 17 day of October 2014

Cristin G. Foster
Signature of Notary

Seal

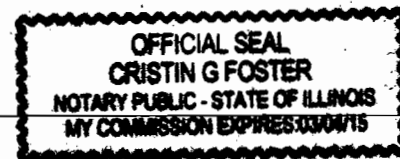


*Insert EX-107 legal name of the applicant

Notarization:
Subscribed and sworn to before me
this 16 day of October 2014

Cristin G. Foster
Signature of Notary

Seal



After paginating the entire, completed application, indicate in the chart below, the page numbers for the attachments included as part of the project's application for permit:

INDEX OF ATTACHMENTS		
ATTACHMENT NO.		PAGES
1	Applicant/Coapplicant Identification including Certificate of Good Standing	46 – 48
2	Site Ownership	49 – 53
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	54 – 55
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	56 – 57
5	Flood Plain Requirements	58 – 62
6	Historic Preservation Act Requirements	63 – 64
7	Project and Sources of Funds Itemization	65 – 67
8	Obligation Document if required	68
9	Cost Space Requirements	69 – 70
10	Discontinuation	NA
11	Background of the Applicant	71 – 75
12	Purpose of the Project	76 – 98
13	Alternatives to the Project	99 – 111
14	Size of the Project	112 – 115
15	Project Service Utilization	116 – 118
16	Unfinished or Shell Space	NA
17	Assurances for Unfinished/Shell Space	NA
18	Master Design Project	NA
19	Mergers, Consolidations and Acquisitions	NA
	Service Specific:	
20	Medical Surgical Pediatrics, Obstetrics, ICU	NA
21	Comprehensive Physical Rehabilitation	NA
22	Acute Mental Illness	NA
23	Neonatal Intensive Care	NA
24	Open Heart Surgery	NA
25	Cardiac Catheterization	NA
26	In-Center Hemodialysis	NA
27	Non-Hospital Based Ambulatory Surgery	NA
28	Selected Organ Transplantation	NA
29	Kidney Transplantation	NA
30	Subacute Care Hospital Model	NA
31	Children's Community-Based Health Care Center	NA
32	Community-Based Residential Rehabilitation Center	NA
33	Long Term Acute Care Hospital	NA
34	Clinical Service Areas Other than Categories of Service	119 – 165
35	Freestanding Emergency Center Medical Services	NA
	Financial and Economic Feasibility:	
36	Availability of Funds	166 – 179
37	Financial Waiver	180
38	Financial Viability	181
39	Economic Feasibility	182 – 192
40	Safety Net Impact Statement	193 – 195
41	Charity Care Information	196 – 197
42	Assurances Letter	198

Attachments

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Advocate Christ Medical Center – Trauma I Center/Emergency Department Expansion and Renovation			
Street Address: 4440 West 95 th Street			
City and Zip Code: Oak Lawn 60453-2699			
County: Cook	Health Service Area	7	Health Planning Area: A-04

Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: Advocate Health and Hospitals Corporation d/b/a Advocate Christ Medical Center			
Address: 4440 West 95 th Street Oak Lawn 60453-2699			
Name of Registered Agent: Gail D. Hasbrouck			
Name of Chief Executive Officer: Kenneth Lukhard, President, Advocate Christ Medical Center			
CEO Address: 4440 West 95 th Street Oak Lawn 60453-2699			
Telephone Number: 708-684-5010			

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Advocate Christ Medical Center – Trauma I Center/Emergency Department Expansion and Renovation			
Street Address: 4440 West 95 th Street			
City and Zip Code: Oak Lawn 60453-2699			
County: Cook	Health Service Area	7	Health Planning Area: A-04

Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: Advocate Health Care Network			
Address: 3075 Highland Parkway, Downers Grove, IL 60515			
Name of Registered Agent: Gail D. Hasbrouck			
Name of Chief Executive Officer: James H. Skogsbergh, President and Chief Executive Officer			
CEO Address: 3075 Highland Parkway, Downers Grove, IL 60515			
Telephone Number: 630-929-8700			



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

ADVOCATE HEALTH AND HOSPITALS CORPORATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 12, 1906, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



Authentication #: 1423500438

Authenticate at: <http://www.cyberdriveillinois.com>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 23RD day of AUGUST A.D. 2014 .

Jesse White

SECRETARY OF STATE



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

ADVOCATE HEALTH CARE NETWORK, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 14, 1923, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



Authentication #: 1423500446

Authenticate at: <http://www.cyberdriveillinois.com>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 23RD day of AUGUST A.D. 2014 .

Jesse White

SECRETARY OF STATE

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Advocate Health and Hospitals Corporation
Address of Site Owner: 3075 Highland Parkway, Downers Grove, IL 60515
Street Address or Legal Description of Site: Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.
APPEND DOCUMENTATION AS <u>ATTACHMENT-2</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Proof of site ownership is appended as Attachment 2, Exhibit 1.

COMMITMENT FOR TITLE INSURANCE



Chicago Title Insurance Company

Providing Title Related Services Since 1847

CHICAGO TITLE INSURANCE COMPANY, a Missouri corporation, herein called the Company, for a valuable consideration, hereby commits to issue its policy or policies of title insurance, as identified in Schedule A (which policy or policies cover title risks and are subject to the Exclusions from Coverage and the Conditions and Stipulations as contained in said policy/ies) in favor of the proposed Insured named in Schedule A, as owner or mortgagee of the estate or interest in the land described or referred to in Schedule A, upon payment of the premiums and charges therefor, all subject to the provisions of Schedules A and B hereof and to the Commitment Conditions and Stipulations which are hereby incorporated by reference and made a part of the Commitment. A complete copy of the Commitment Conditions and Stipulations is available upon request and such include, but are not limited to, the proposed Insured's obligation to disclose, in writing, knowledge of any additional defects, liens, encumbrances, adverse claims or other matters which are not contained in the Commitment; provisions that the Company's liability shall in no event exceed the amount of the policy/ies as stated in Schedule A hereof, must be based on the terms of this Commitment, shall be only to the proposed Insured and shall be only for actual loss incurred in good faith reliance on this Commitment; and provisions relating to the General Exclusions, to which the policy/ies will be subject unless the same are disposed of to the satisfaction of the Company.

This Commitment shall be effective only when the identity of the proposed Insured and the amount of the policy or policies committed for have been inserted in Schedule A hereof by the Company, either at the time of the issuance of this Commitment or by issuance of a revised Commitment.

This Commitment is preliminary to the issuance of such policy or policies of title insurance and all liability and obligations hereunder shall cease and terminate six months after the effective date hereof or when the policy or policies committed for shall issue, whichever first occurs, provided that the failure to issue such policy or policies is not the fault of the Company.

This Commitment is based upon a search and examination of Company records and/or public records by the Company. Utilization of the information contained herein by an entity other than the Company or a member of the Chicago Title and Trust Family of Title Insurers for the purpose of issuing a title commitment or policy or policies shall be considered a violation of the proprietary rights of the Company of its search and examination work product.

This Commitment shall not be valid or binding until signed by an authorized signatory.

Issued By:

CHICAGO TITLE INSURANCE COMPANY
P.O. BOX 827
WHEATON, IL 60189-0827

Refer Inquiries To:

(630)871-3500



CHICAGO TITLE INSURANCE COMPANY

Harry S. Gay
Authorized Signatory

Commitment No.: 1410 008284161 IL

CONTACT AREA

363

07/07/05

**CHICAGO TITLE INSURANCE COMPANY
COMMITMENT FOR TITLE INSURANCE
SCHEDULE A**

YOUR REFERENCE: ADVOCATE CHRIST HOSPITAL MEDICAL CENTER ORDER NO.: 1410 008284161 UL

EFFECTIVE DATE: APRIL 27, 2005

1. POLICY OR POLICIES TO BE ISSUED:

LOAN POLICY:	ALTA LOAN 1992
AMOUNT:	\$10,000.00
PROPOSED INSURED:	TO COME

2. THE ESTATE OR INTEREST IN THE LAND DESCRIBED OR REFERRED TO IN THIS COMMITMENT AND COVERED HEREIN IS A FEE SIMPLE UNLESS OTHERWISE NOTED.

**3. TITLE TO SAID ESTATE OR INTEREST IN SAID LAND IS AT THE EFFECTIVE DATE VESTED IN:
ADVOCATE HEALTH AND HOSPITALS CORPORATION**

4. MORTGAGE OR TRUST DEED TO BE INSURED:

TO COME.

**RECEIVED
JG3**

PAGE A1

07/01/05

10:13:20

**CHICAGO TITLE INSURANCE COMPANY
COMMITMENT FOR TITLE INSURANCE
SCHEDULE A (CONTINUED)**

ORDER NO.: 1410 008284161 UL

5. THE LAND REFERRED TO IN THIS COMMITMENT IS DESCRIBED AS FOLLOWS:

PARCEL ONE:

**SOUTH 1/2 OF THE EAST 1/2 OF THE EAST 1/2 OF THE SOUTHWEST 1/4 IN SECTION 3,
TOWNSHIP 37 NORTH, RANGE 13, EAST OF THE THIRD PRINCIPAL MERIDIAN,**

EXCEPT FROM ABOVE THE FOLLOWING DESCRIBED PROPERTY

**THAT PART OF THE SOUTHWEST 1/4 OF SECTION 3, TOWNSHIP 37 NORTH, RANGE 13, EAST OF
THE THIRD PRINCIPAL MERIDIAN, BOUNDED AND DESCRIBED AS FOLLOWS:**

**BEGINNING AT THE POINT OF INTERSECTION OF A LINE DRAWN 40.00 FEET WEST OF AND
PARALLEL WITH THE EAST LINE OF SAID SOUTHWEST 1/4 WITH A LINE DRAWN 50.00 FEET
NORTH OF AND PARALLEL WITH THE SOUTH LINE OF SAID SOUTHWEST 1/4; THENCE WEST
222.03 FEET ALONG A LINE 50.00 FEET NORTH OF AND PARALLEL WITH THE SOUTH LINE OF
SAID SOUTHWEST 1/4, BEING ALSO THE NORTH LINE OF WEST 95TH STREET IN ACCORDANCE
WITH PLAT OF DEDICATION RECORDED MAY 27, 1950 AS DOCUMENT NO. 17218540; THENCE
NORTH 177.05 FEET ALONG A LINE FORMING AN ANGLE OF 89 DEGREES 54 MINUTES 37
SECONDS AS MEASURED FROM EAST TO NORTH WITH SAID NORTH LINE OF WEST 95TH STREET;
THENCE EAST 24.70 FEET PARALLEL WITH SAID NORTH LINE OF WEST 95TH STREET; THENCE
NORTH 72.34 FEET PARALLEL WITH THE EAST LINE OF SAID SOUTHWEST 1/4; THENCE EAST
197.28 FEET PARALLEL WITH SAID NORTH LINE OF WEST 95TH STREET TO THE WEST LINE OF
SOUTH KOSTNER AVENUE, BEING A LINE 40.00 FEET WEST OF THE EAST LINE OF SAID
SOUTHWEST 1/4, IN ACCORDANCE WITH THE AFORESAID PLAT OF DEDICATION; THENCE SOUTH
249.39 FEET ALONG THE WEST LINE OF SOUTH KOSTNER AVENUE TO THE HEREINAFORE
DESCRIBED POINT OF BEGINNING, ALL IN COOK COUNTY, ILLINOIS.**

PARCEL TWO:

**THE EAST 3/4 OF THE SOUTHWEST 1/4 OF THE SOUTHEAST 1/4 OF SECTION 3, TOWNSHIP 37
NORTH, RANGE 13, EAST OF THE THIRD PRINCIPAL MERIDIAN,**

(EXCEPT THE SOUTH 375 FEET THEREOF;

**ALSO EXCEPT THAT PART LYING WITHIN THE SOUTH 400 FEET OF THE WEST 262.50 FEET OF
SAID EAST 3/4 OF SOUTHWEST 1/4 OF SOUTHEAST 1/4 OF SECTION 3;**

ALSO EXCEPT THE EAST 33 FEET AND THE NORTH 33 FEET THEREOF; AND

**ALSO EXCEPT THAT PART LYING WITHIN THE NORTH 669 FEET OF THE EAST 525 FEET OF
SAID SOUTHWEST 1/4 OF SOUTHEAST 1/4 OF SECTION 3), IN COOK COUNTY, ILLINOIS.**

PARCEL THREE:

**THE EAST 33 FEET OF THE NORTH 423 FEET OF THE SOUTH 823 FEET OF THE WEST 1/4 OF
SAID SOUTHWEST 1/4 OF SOUTHEAST 1/4 OF SECTION 3, TOWNSHIP 37 NORTH, RANGE 13,
EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS.**

PARCEL FOUR:

80V AC
JG3

PAGE 12

07/01/05

10:13:20

CHICAGO TITLE INSURANCE COMPANY
COMMITMENT FOR TITLE INSURANCE
SCHEDULE A (CONTINUED)

ORDER NO.: 1410 008284161 UL

LOT 3 IN SUBDIVISION OF ALL OF LOT 3 AND LOT 2 (EXCEPT THE EASTERLY 1/2 OF SAID LOT 2 MEASURED FROM THE CENTER OF THE NORTH LINE OF SAID OF SAID LOT 2 TO A POINT IN THE CENTER OF THE SOUTHEASTERLY LINE OF SAID LOT 2) IN THE RESUBDIVISION OF CALEDONIA PARK, BEING A SUBDIVISION OF THAT PART OF THE FRACTIONAL EAST 1/2 OF THE SOUTHEAST 1/4 OF SECTION 30, TOWNSHIP 41 NORTH, RANGE 13, EAST OF THE THIRD PRINCIPAL MERIDIAN, LYING NORTH OF THE CALEDONIA ROAD (EXCEPT THE NORTH 30 ACRES THEREOF), IN COOK COUNTY, ILLINOIS.

RECEIVED

PAGE A 3

10:13:21

Operating Identity/Licensee

[Provide this information for each applicable facility, and insert after this page.]

Exact Legal Name: Advocate Health and Hospitals Corporation d/b/a Advocate Christ Medical Center

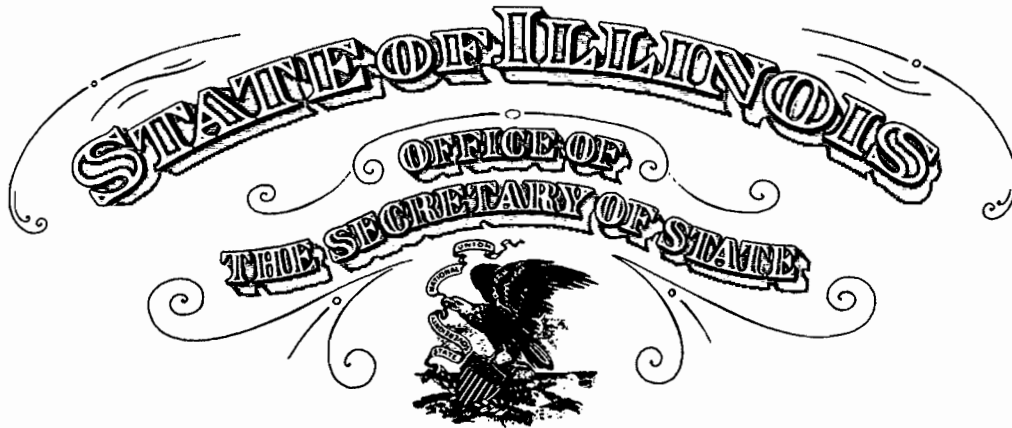
Address: 4440 W. 95th Street, Oak Lawn, IL 60453

- | | | |
|--|--|--------------------------------|
| ☒ Non-profit Corporation | ☐ Partnership | |
| ☐ For-profit Corporation | ☐ Governmental | |
| ☐ Limited Liability Company | ☐ Sole Proprietorship | ☐ Other |

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

A Certificate of Good Standing for Advocate Health and Hospitals Corporation d/b/a Advocate Christ Medical Center is appended as Attachment 3, Exhibit 1.



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

ADVOCATE HEALTH AND HOSPITALS CORPORATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 12, 1906, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



Authentication #: 1423500438

Authenticate at: <http://www.cyberdriveillinois.com>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 23RD day of AUGUST A.D. 2014 .

Jesse White

SECRETARY OF STATE

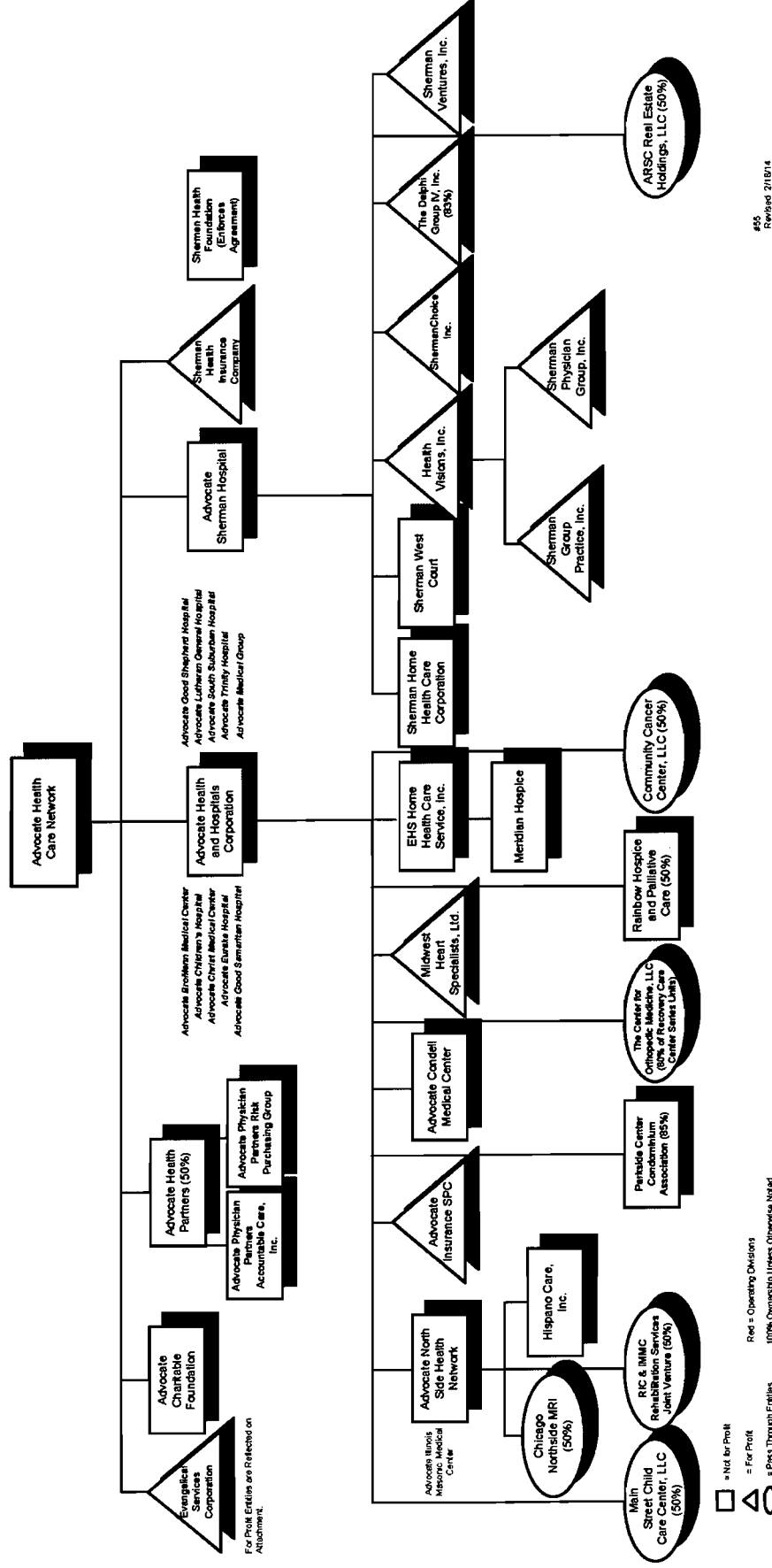
Organizational Relationships

Provide (for each co-applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

APPEND DOCUMENTATION AS ATTACHMENT-4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Attachment 4, Exhibit 1, is an organization chart showing all of the organizations relevant to this project including Advocate Health Care Network, Advocate Health and Hospitals Corporation and Advocate Christ Medical Center.

On October 15, 2014 Advocate Health Care Network and Advocate Health and Hospitals Corporation, together with other co-applicants, filed a series of applications for change of ownership (COE) exemptions. These COE applications relate to a proposed merger with NorthShore University HealthSystem. Subject to Review Board and other regulatory approvals, that transaction is targeted for closing on January 1, 2015. Under that merger the name of Advocate Health Care Network will change to Advocate NorthShore Health Partners, but the corporate identity will remain the same. There will be no change in the name of the licensed entity and consequently there are no changes in Applicants (albeit a change in the name of one of the corporate entities).



Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at www.FEMA.gov or www.illinoisfloodmaps.org. **This map must be in a readable format.** In addition please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2005-5 (<http://www.hfsrb.illinois.gov>).

APPEND DOCUMENTATION AS ATTACHMENT -5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

In the case of Advocate Christ Medical Center, there is no published flood map, thus the lack of documentation is the proof that this site is nowhere near a Special Flood Hazard Area.

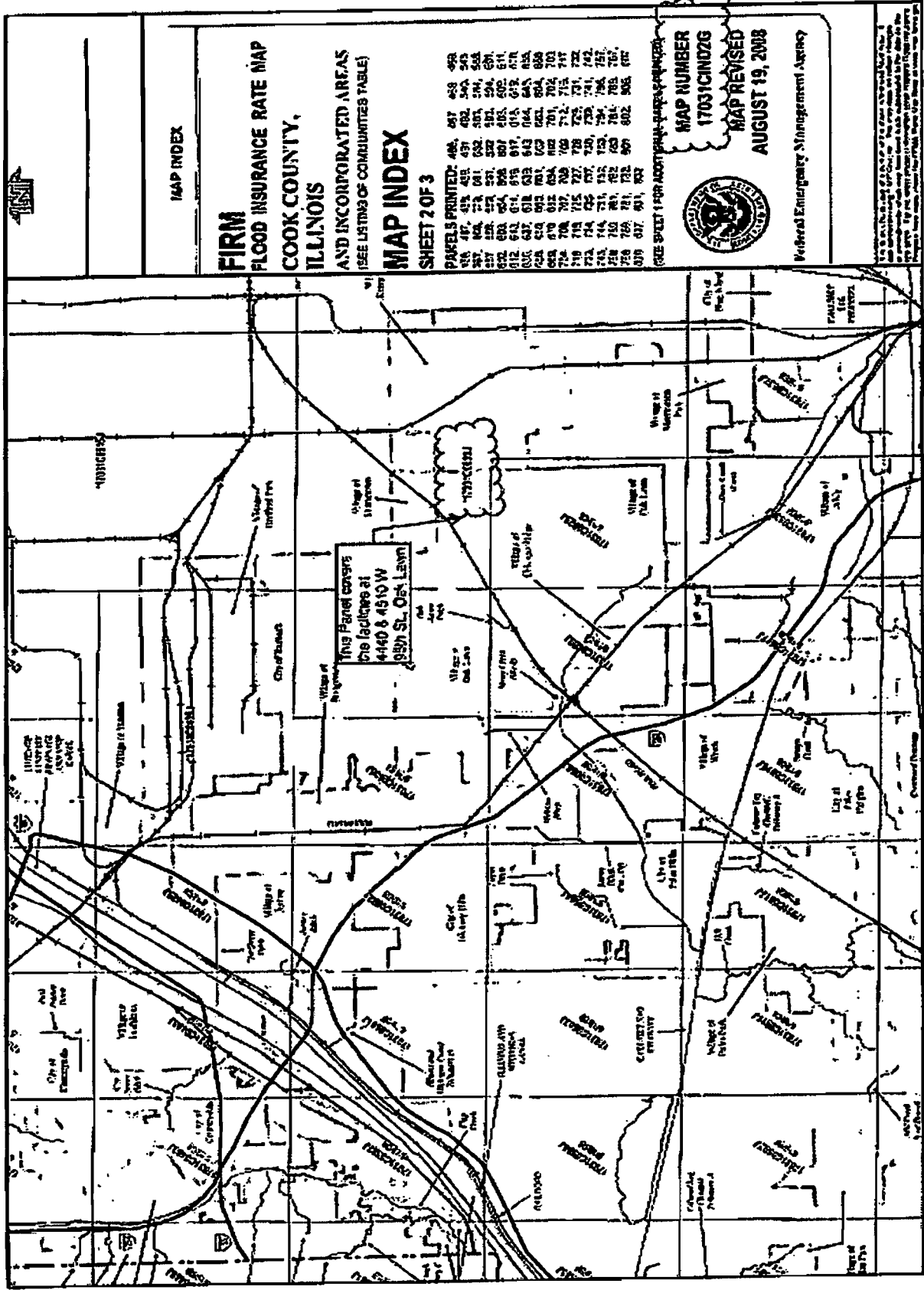
Exhibit 1, PDF (FM1703CIND2G-3.pdf) shows the Map Panel number within a red 'cloud'. This Panel Number is preceded by an asterisk. Exhibit 2 shows the meaning of this asterisk located elsewhere on the same document.

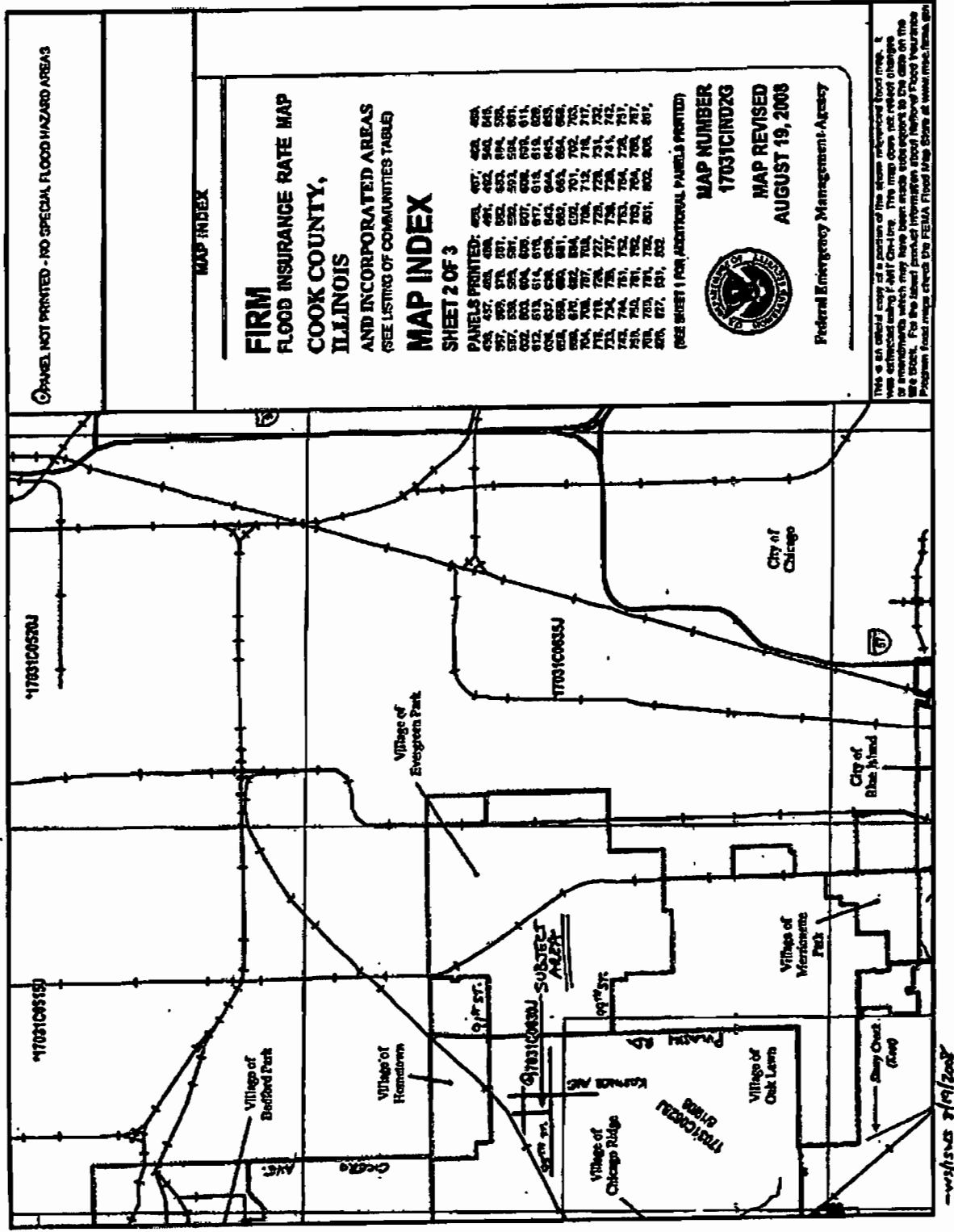
The asterisk footnote is the official statement given by FEMA indicating that no Special Flood Hazard Areas are contained within the boundaries of the stated Map Panel.

Attached is the last flood plain documentation Advocate Christ Medical Center has on file.

See attached Attachment 5, Exhibits 3 and 4.

The proposed Project complies with the requirements of Illinois Executive Order # 2005-5.





UNIVERSITY OF ILLINOIS
AT URBANA-CHAMPAIGN

Institute of Natural Resource Sustainability
Illinois State Water Survey

2204 Griffith Drive, MC-674
Champaign, Illinois 61820-7463



Special Flood Hazard Area Determination
pursuant to Governor's Executive Order 5 (2006)
(supersedes Governor's Executive Order 4 (1979))

Requester: Wendy Mulvihill, Planning Manager Business Development
Address: Advocate Christ Medical Center, POB #408, 4440 W. 95th St.
City, state, zip: Oak Lawn, IL 60453 Telephone: (708) 684-5765

Site description of determination:

Site address: Advocate Christ Medical Center (incl. Physician's Pavilion) & Hope Children's Hospital, 4440 W. 95th St.
City, state, zip: Oak Lawn, IL 60453
County: Cook Sec: 1/4 of SW 1/4 Section: 3 T. 37 N. R. 13 E. PM: 3rd
Subject area: Parcels 24-03-318-016-0000 & -017-0000, which comprise the area bounded by S. Kilbourn Ave. on the west, S. Kostner Ave. on the east, W. 95th St. on the south, and W. 93rd St. on the north.

The property described above IS NOT located in a Special Flood Hazard Area or a shaded Zone X floodzone.
Floodway mapped: N/A Floodway on property: No
Sources used: FEMA Flood Insurance Rate Map Index 17031CIND2G; www.cookcountysassessor.com; advocathealth.com
Community name: Village of Oak Lawn, IL Community number: 170137
Panel/map number: 17031C0630 J* Effective Date: August 19, 2008
Flood zone: X [unshaded]* Base flood elevation: N/A ft NGVD 1929

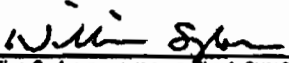
- N/A a. The community does not currently participate in the National Flood Insurance Program (NFIP). NFIP flood insurance is not available; certain State and Federal assistance may not be available.
*X b. Panel not printed: no Special Flood Hazard Area on the panel (panel designated all Zone C or unshaded X).
N/A c. No map panels printed: no Special Flood Hazard Areas within the community (NSFHA).

The primary structure on the property:

- N/A d. Is located in a Special Flood Hazard Area. Any activity on the property must meet State, Federal, and local floodplain development regulations. Federal law requires that a flood insurance policy be obtained as a condition of a federally-backed mortgage or loan that is secured by the building.
N/A e. Is located in shaded Zone X or B (500-yr floodplain). Conditions may apply for local permits or Federal funding.
X f. Is not located in a Special Flood Hazard Area or 500-year floodplain area shown on the effective FEMA map.
N/A g. A determination of the building's exact location cannot be made on the current FEMA flood hazard map.
N/A h. Exact structure location is not available or was not provided for this determination.

Note: This determination is based on the effective Federal Emergency Management Agency (FEMA) flood hazard reference for the subject area. This letter does not imply that the referenced property will be free from water damage. Property not in a Special Flood Hazard Area may be damaged by a flood greater than that illustrated on the FEMA map, by local drainage problems or runoff not illustrated on the source map, or by failure of flood control structures. This letter does not create liability on the part of the Illinois State Water Survey or employee thereof for any damage that results from reliance on this determination. This letter does not exempt the project from local stormwater management regulations.

Questions concerning this determination may be directed to Bill Saylor (217/333-0447) at the Illinois State Water Survey. Questions concerning requirements of Governor's Executive Order 5 (2006), or State floodplain regulations, may be directed to John Lentz (847/608-3100 x2022) at the Illinois Department of Natural Resources' Office of Water Resources.


William Saylor, 217-244-5459, Illinois State Water Survey

Title: ISWS Floodplain Information Specialist

Date: 8/19/2008

telephone 217-244-5459 • fax 217-333-4983 • www.sws.uiuc.edu

Form rev. -3/01/2008

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT-6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Attachment 6, Exhibit 1 is a copy of the letter received from the Historic Resources Preservation Agency which documents that no historic, architectural, or archeological sites exist within the project area. The Project is in compliance with the Illinois Historic Resources Preservation Act.



**Illinois Historic
Preservation Agency**

1 Old State Capitol Plaza, Springfield, IL 62701-1512

FAX (217) 524-75

www.illinoishistory.gov

Cook County

Oak Lawn

**Expansion and Modernization for Trauma 1 Center/Emergency Department, Advocate Christ Medical Center
4440 W. 95th St.**

IHPA Log #020081414

August 27, 2014

Janet Scheuerman

PRISM Healthcare Consulting

1808 Woodmere Drive

Valparaiso, IN 46383

Dear Ms. Scheuerman:

This letter is to inform you that we have reviewed the information provided concerning the referenced project

Our review of the records indicates that no historic, architectural or archaeological sites exist within the project area.

Please retain this letter in your files as evidence of compliance with Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et. seq.). This clearance remains in effect for two years from date of issuance. It does not pertain to any discovery during construction, nor is it a clearance for purposes of the Illinois Human Skeletal Remains Protection Act (20 ILCS 3440).

If you have any further questions, please contact me at 217/785-5027.

Sincerely,

Anne E. Haaker

Anne E. Haaker

Deputy State Historic

Preservation Officer

For TTY communication, dial 888-440-9009. It is not a voice or fax line.

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must equal.

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	581,561	349,474	931,035
Site Survey and Soil Investigation	75,000	15,000	90,000
Site Preparation	1,495,447	356,461	1,851,908
Off Site Work	0	0	0
New Construction Contracts	570,821	2,643,324	3,214,145
Modernization Contracts	27,560,966	3,673,693	31,234,659
Contingencies	4,177,161	812,228	4,989,389
Architectural/Engineering Fees	2,529,790	558,220	3,088,010
Consulting and Other Fees	4,348,355	678,645	5,027,000
Movable or Other Equipment (not in construction contracts)	11,627,390	658,610	12,286,000
Bond Issuance Expense (project related)	574,533	126,117	700,650
Net Interest Expense During Construction (project related)	8,057,555	1,768,731	9,826,286
Fair Market Value of Leased Space or Equipment	0	0	0
Other Costs To Be Capitalized	10,638,400	1,641,600	12,280,000
Acquisition of Building or Other Property (excluding land)	0	0	0
TOTAL USES OF FUNDS	72,236,979	13,282,103	85,519,082
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	24,751,999	4,715,083	29,467,082
Pledges			0
Gifts and Bequests			0
Bond Issues (project related)	47,484,980	8,567,020	56,052,000
Mortgages			0
Leases (fair market value)			0
Governmental Appropriations			0
Grants			0
Other Funds and Sources			0
TOTAL SOURCES OF FUNDS	72,236,979	13,282,103	85,519,082
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Advocate Christ Medical Center - Emergency Department Expansion

Summary of Project Cost and Sources of Funds as of 10/07/2014

PROJECT COSTS:

Project Costs

1. Preplanning Costs	\$931,035
a. Architect/engineer fees (HDR / GBA / Pepper)	
2. Site Survey and Soil Investigation	\$90,000
3. Site Preparation	\$1,851,908
a. Pepper Construction	
4. Off Site Work N/A	
5. New Construction	\$3,214,145
a. Pepper Construction	
6. Modernization Contracts	\$31,234,659
a. Pepper Construction	
7. Contingencies	\$4,989,389
a. Pepper Construction	
8. Architectural/Engineering Fees	\$3,088,010
a. HDR / GBA (Basic Services)	
9. Consulting and Other Fees	\$5,027,000
a. HDR additional services	1,260,000
b. CON Fee	100,000
c. Con Legal	45,000
d. CON Consultant	90,000
e. Building permit / Code review (B & F Tech) fees	512,000
f. Other Consultant fees	2,030,000
g. IDPH Fees	85,000
h. Testing Materials fees	85,000
i. Abatement management (Midwest)	90,000
j. Project management	490,000
k. MWRD	40,000

10. Movable or Other Equipment	\$12,286,000
a. Medical / Misc. Equipment	11,394,357
b. Furniture / FF &E	688,745
c. Signage	79,530
d. Graphics/artwork	91,370
e. Cubicle curtains	31,998
11. Bond Issuance Expense (project related)	\$700,650
12. Net Interest Expense During Construction	\$9,826,286
13. Fair Market Value of Leases Space or Equip	0
14. Other Costs to be Capitalized	\$12,280,000
a. Pepper GC / Fees / Misc	5,220,000
b. Owner contingency	1,714,500
c. Voice / Data	2,678,000
d. Cerner / RTLS	2,649,500
e. Final Audit	18,000
15. Acquisition of Buildings or Other Property	0
Total Project Costs	\$85,519,082

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.

Indicate the stage of the project's architectural drawings:

☐ None or not applicable

☐ Preliminary

☒ Schematics

☐ Final Working

Anticipated project completion date (refer to Part 1130.140): December 31, 2020

Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):

☐ Purchase orders, leases or contracts pertaining to the project have been executed.

☐ Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies

☒ Project obligation will occur after permit issuance.

APPEND DOCUMENTATION AS ATTACHMENT-8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Cost Space Requirements

Provide in the following format, the department/area **DGSF** or the building/area **BGSF** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							
APPEND DOCUMENTATION AS <u>ATTACHMENT-9</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.							

Project Cost / Space Requirements						
Department	Project Cost	Gross Square Feet		Amount of Proposed Total GSF That Is:		
		Existing	Proposed	New Construction	Remodeled	As Is
Reviewable / Clinical						
Trauma	\$ 8,791,241	1,432	7,342	0	7,342	0
Triage	\$ 1,762,582	726	1,447	1,447	0	0
Emergency Department Adult	\$ 27,233,341	14,984	22,737	0	22,737	0
Emergency Department Pediatric	\$ 15,964,372	6,097	13,324	0	13,324	0
Total Emergency Department	\$ 43,197,713	21,081	36,061		36,061	
Phase 1 Recovery ¹	\$ 2,094,872	5,495	10,252	0	1,751	8,501
Phase 2 Recovery ¹	\$ 9,795,334		37,098	0	8,184	28,914
GI/Endoscopy	\$ 3,200,098	11,798	12,425	0	2,672	9,753
Cast Room	\$ 151,698	966	130	0	130	966
General Radiology	\$ 2,289,912	20,621	22,531	0	1,910	20,621
Ultra sound Mobile	\$ 657,357	14,060	14,614	0	554	14,060
TEE	\$ 296,172	191	248	0	248	0
Total Clinical	\$ 72,236,979	76,370	142,148	1,447	58,852	82,815
Non Clinical						
Admin	\$ 6,104,455	20,152	26,160	625	7,670	17,865
Public spaces	\$ 4,473,412	22,826	28,906	4,518	1,562	22,826
Building Components	\$ 2,704,236	343,846	345,698	445	1,429	342,024
Total Non-Clinical	\$ 13,282,103	386,824	400,764	7,388	10,661	382,715
Total Project	\$ 85,519,082	463,194	542,912	8,835	69,513	465,530
						35,079

¹ Advocate Christ Medical Center's facility records have only one value for Phase I and Phase II Recovery.

Note: Vacated space represents space vacated to accommodate another department or service that is part of the Project. At Project completion there will be no vacated space.

SECTION III – BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

Criterion 1110.230 – Background, Purpose of the Project, and Alternatives

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT-11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.

Facility	Location	License No.	Joint Commission Accreditation	DNV Accreditation No.
Advocate Christ Medical Center	4440 W. 95 St. Oak Lawn, IL	0000315	Not Applicable	135696-2013-AHC-USA-NIAHO
Advocate BroMenn Medical Center	1304 Franklin Ave. Normal, IL	0005645	Not Applicable	127532-2012-AHC-USA-NIAHO
Advocate Condell Medical Center	801 S. Milwaukee Ave. Libertyville, IL	0005579	Not Applicable	147414-2013-AHC-USA-NIAHO
Advocate Eureka Hospital	101 S. Major Eureka, IL	0005652	Not Applicable	127988-2012-AHC-USA-NIAHO
Advocate Good Samaritan Hospital	3815 Highland Avenue Downers Grove, IL	0003384	Not Applicable	115804-2012-AHC-USA-NIAHO
Advocate Good Shepherd Hospital	450 W. Highway, #22 Barrington, IL	0003457	Not Applicable	114892-2012-AHC-USA-NIAHO
Advocate Illinois Masonic Medical Center	836 W. Wellington Chicago, Illinois	0005165	4068	Not yet surveyed
Advocate Lutheran General Hospital	1775 Dempster Park Ridge, IL	004796	Not Applicable	117368-2012-AHC-USA-NIAHO
Advocate South Suburban Hospital	17800 S. Kedzie Ave. Hazel Crest, IL	0004697	Not Applicable	127995-2012-AHC-USA-NIAHO
Advocate Sherman Hospital	1425 N. Randall Rd. Elgin , IL	0005884	7339	Not yet surveyed
Advocate Trinity Hospital	2320 E. 93 rd St. Chicago, Il	0004176	Not Applicable	1120735-2012-AHC-USA-NIAHO

The license for Advocate Christ Medical Center (Medical Center) is included as Attachment 11, Exhibit 1.

The most recent DNV accreditation certificate for Advocate Christ Medical Center is included as Attachment 11, Exhibit 2. Advocate Christ Medical Center participates in Medicaid and Medicare.

2. *A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.*

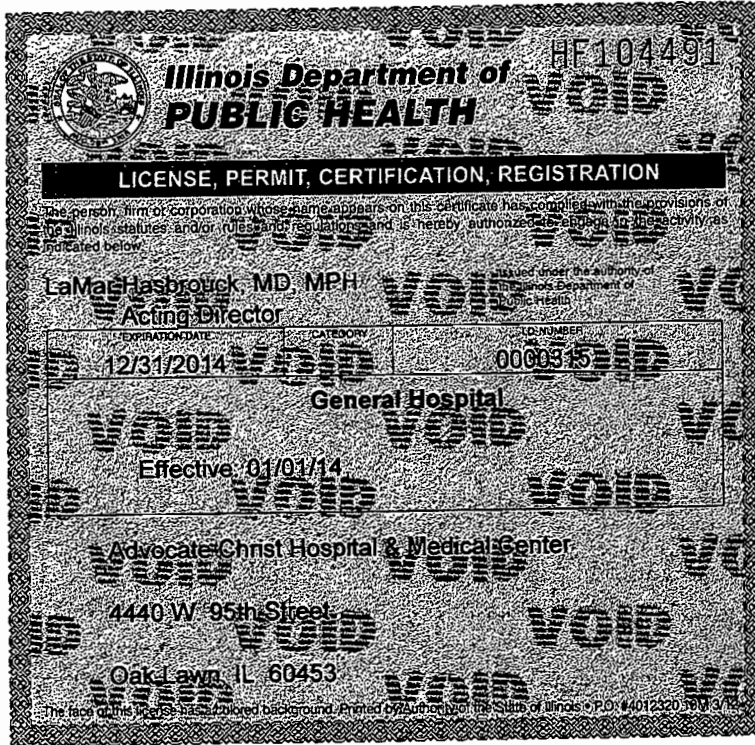
By the signatures on this application, Advocate Health and Hospitals Corporation and Advocate Health Care Network hereby attest that there have been no adverse actions against any facility owned and/or operated by Advocate Health and Hospitals Corporation by any regulatory agency which would affect its ability to operate as a licensed entity during the three years prior to the filing of this application.

3. *Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.***

By the signatures on this application, Advocate Health and Hospitals Corporation and Advocate Health Care Network hereby authorize the Health Facilities and Services Review Board and the Department of Public Health to access information in order to verify any documentation or information submitted in response to the requirements of this subsection, or to obtain any documentation or information which the State Board or Department of Public Health find pertinent to this subsection.

4. *If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.*

Not applicable. This is the first certificate of need filed by Advocate Christ Medical Center in 2014.



← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 12/31/2014
Lic Number 0000315

Date Printed 11/22/2013

Advocate Christ Hospital & Medical Ce
4440 W. 95th Street
Oak Lawn, IL 60453

FEE RECEIPT NO.



DNV HEALTHCARE INC.

CERTIFICATE OF ACCREDITATION

Certificate No. 135696-2013-AHC-USA-NIAHO

This is to certify that

Advocate Christ Medical Center & Hope Children's Hospital

4440 W. 95th Street, Oak Lawn, IL 60453

Complies with the requirements of the:

NIAHO® Hospital Accreditation Program

Pursuant to the authority granted to Det Norske Veritas Healthcare, Inc. by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, this organization is deemed in compliance with the Medicare Conditions of Participation for Hospitals (42 C.F.R. §482). This certificate is valid for a period of three (3) years from the Effective Date of Accreditation.

Effective Date of Accreditation:

April 15, 2013

for the Accreditation Body:

DET NORSKE VERITAS
HEALTHCARE, INC.
HOUSTON, TEXAS

Patrick Horine
Executive Vice President, Accreditation



Yehuda Dror
President

Lack of continual fulfillment of the conditions set out in the Certification/Accreditation Agreement may render this Certificate invalid.

ACCREDITED UNIT: DNV HEALTHCARE INC., 400 TECHNECENTER DRIVE, SUITE 100 MILFORD, OHIO 45150, OH, UNITED STATES, TEL: 513-947-8334
WWW.DNVACCREDITATION.COM

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]
4. Cite the sources of the information provided as documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate**.

For projects involving modernization, describe the conditions being upgraded if any. For facility projects, include statements of age and condition and regulatory citations if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Report.

APPEND DOCUMENTATION AS ATTACHMENT-12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

1. *Document that the project will provide health services that improve the health care or well-being of the market area population to be served.*

Advocate Christ Medical Center (ACMC, Medical Center) has served Chicago's southwest suburbs and beyond for more than half a century, during which time improving the health and well-being of the population it serves has dominated its planning and ongoing development efforts. What began as a community hospital is now a major teaching hospital with a comprehensive range of tertiary and quaternary services including a Level I Adult and Pediatric Trauma/Resuscitation Center (Trauma Center), one of the busiest comprehensive emergency departments in the State of Illinois, and a nationally recognized cardiovascular service. Many cardiovascular patients arrive at the Medical Center and are first seen in the Trauma Center or Emergency Department.

This Project proposes to expand and modernize the current Level I Trauma Center and the Emergency Department with facilities that are appropriately sized to meet growing demand and functionally designed to ensure the delivery of high quality care. In addition, the Project proposes to replace the inpatient endoscopy suite and expand the Phase I and Phase II recovery capacity to support not only the endoscopy suite but the growing catheterization service that are currently located proximate to the recovery stations. Finally, the Project includes the relocation of the triage area, cast room, and transesophageal echo service.

Advocate Children's Hospital – Oak Lawn is located on the campus of Advocate Christ Medical Center. The Level I Trauma Center and the Emergency Department located in the Medical Center serve both hospitals and treat both pediatric and adult patients; in fact, approximately 30 percent of the patients seen in the combined unit are children.

The Medical Center's trauma and emergency services provide residents of the community and of the region immediate access to essential trauma and emergency services. These services are also the focal point for local and regional emergency preparedness. In conjunction with the full range of back- up services at the Medical Center (medical surgical, intensive care, obstetrics, and ancillary services including surgery, imaging and laboratory) as well as highly credentialed physicians, nurses and support staff, the trauma and emergency services provide not only life-saving services but also other care that improves the health care and well-being of the market population.

2. Define the planning area or market area, or other, as defined per the applicant's definition.

The Medical Center has multiple planning area definitions. For inpatient services, the planning area is defined as a primary service area, a secondary service area, and an extended service area that includes the rest of Illinois and out-of -state patients. Patients residing in the primary and secondary service areas typically use all of the Medical Center's services, while patients from the more distant areas are more likely to use the advanced trauma as well as tertiary and quaternary services that may not be available in their local communities. Detailed patient origin is located as Attachment 12, Exhibit 1. A map of the Medical Center's service area is provided as Attachment 12, Exhibit 2.

The Medical Center is the only Level I Trauma Center in Region VII Emergency Medical Services (EMS) System which includes all or parts of 7 counties. It extends east to the Indiana border, south to Kankakee County, and reaches as far west as Grundy County and north to parts of Will County. It has the fastest growing population of any of the regions in the State. The Medical Center is the Regional Health Care Coordinating Council for Emergency Preparedness in Region VII. As such, it has an extraordinary role in times of a "medical surge," which is defined as a disaster affecting one of the hospitals in the region. Under a "medical surge" situation, all critical patients are transferred to ACMC making Region VII an important component of the Medical Center's planning area. A map of Region VII EMS System is included as Attachment 12, Exhibit 3.

The following summary patient origin tables illustrate the different markets served by the inpatient and emergency services at ACMC and Advocate Children's Hospital – Oak Lawn and by the Level I Trauma Center.

Comparison of Advocate Christ Medical Center's Inpatient Origin
Trauma, and Emergency Patient Origin, 2013

Advocate Christ Medical Center	Total Inpatients		Emergency Patients		Trauma Patients	
	Number	Percent	Number	Percent	Number	Percent
Primary Service Area (PSA)	166,584	73.8	48,548	77.5	864	39.9
Secondary Service Area (SSA)	30,341	13.4	7,853	12.5	591	27.3
Subtotal PSA and SSA	196,925	87.2	56,401	90.1	1,455	67.2
Other Illinois	26,109	11.6	5,325	8.5	493	22.8
Other States	2,615	1.2	816	1.3	217	10.0
All Other	181	>.01	41	>.01	1	>.01
Total	225,830	100.0	62,583	100.0	2,166	100.0

Source: Medical Center Records (TSI System)

Comparison of Advocate Children's Hospital – Oak Lawn Patient Origin
Trauma, and Emergency Patient Origin, 2013

Advocate Children's Hospital Oak Lawn	Total Inpatients		Emergency Patients		Trauma Patients	
	Number	Percent	Number	Percent	Number	Percent
Primary Service Area (PSA)	45,357	66.6	23,165	75.7	106	39.8
Secondary Service Area (SSA)	9,526	14.0	3,987	13.0	73	27.4
Subtotal PSA and SSA	54,883	80.6	27,152	88.8	179	67.2
Other Illinois	12,073	17.7	3,106	10.2	72	27.1
Other States	1,171	1.7	320	1.0	15	5.6
All Other	7	>.01	3	>.01	0	0
Total	68,134	100.0	30,581	100.0	266	100.0

Source: Medical Center Records (TSI System)

As noted on these tables, the patient origin for inpatient and emergency patients, both adult and pediatric, are very similar with more than 80 percent of inpatients and emergency patients residing in the defined primary and secondary services areas; in contrast, the patient origin for trauma patients is much larger with only 67 percent coming from the defined primary and secondary services and 33 percent coming from beyond.

In summary, the emergency services at the Medical Center and the Children's Hospital serve the local defined service area while the trauma service serves the larger Region VII EMS System area and beyond.

Population

The population of the Medical Center's primary and secondary service areas is detailed on Attachment 12, Exhibits 4 and 5 and summarized below.

Change in Primary and Secondary Service Area Population, 2014 – 2024

Age Cohort	<15	15 – 44	45 – 64	65+	Total
Primary Service Area					
2014	190,351	372,808	240,321	125,894	929,374
2024	188,138	376,165	239,807	145,804	949,194
Percent Change	-1.2	+0.9	->0.1	+15.2	+2.1
Secondary Service Area					
2014	134,397	251,451	164,067	81,282	631,197
2024	126,186	247,610	159,435	91,461	624,692
Percent Change	-6.1	-1.2	-2.8	+12.5	-0.5
Total					
2014	324,748	624,259	404,388	207,176	1,560,571
2024	314,324	623,774	399,243	236,545	1,573,886
Percent Change	-3.2	- > 0.1	-1.3	+14.1	+0.8

Source: Truven, Claritas

As noted in the table, overall the population of the Medical Center's service area is projected to remain stable over the next decade. However, the 65+ group is expected to increase about 14 percent. This growth in the senior population is significant, since this age cohort uses health care services including emergency services at a higher rate than any other adult cohort.

Other Demographic and Socioeconomic Characteristics of Advocate Christ Medical Center's Defined Service Area

Racial Composition

The following tables describe several key demographic characteristics of the Advocate Christ Medical Center/Advocate Children's Hospital – Oak Lawn (ACMC/ACH-OL) service area. The following table is a comparison of the racial characteristics within ACMC/ACH-OL total service

area (primary and secondary) to the State of Illinois and the Chicago Metropolitan Statistical Area (MSA). This table shows that the proportion of minority populations within the ACMC/ACH – OL total service area is higher than the proportions in Illinois or the MSA. Approximately 50 percent of the population residing within ACMC/ACH – OL primary service area are minorities. Nationally, the black population uses emergency services at a higher rate than other minority populations.

2014 Comparison of Racial Composition of ACMC/ACH – OL
Primary and Secondary Service Areas with Illinois and Chicago Metropolitan Area

Race	Percent Primary Service Area	Percent Secondary Service Area	Percent Total Service Area	Percent Region 7 Trauma	Percent Illinois	Percent MSA Area
White	44.3	27.6	37.5	42.2	62.1	51.6
Black	23.5	53.2	35.5	33.1	14.1	17.1
Hispanic	29.2	16.7	24.1	21.3	17.0	23.1
Asian & Pacific Island, Non-Hispanic	1.9	1.1	1.5	1.9	4.8	6.4
All Others	1.1	1.4	1.4	1.5	2.0	1.8
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source: Market Expert (Truven Market Expert)

Average Household Income

The average household income in the Medical Center's service area is compared to the State of Illinois and the Chicago Metropolitan Statistical Area (MSA) in the following table. The proportion of low income households, those typically with the most challenging access to health care is higher in the Medical Center's service area than in Illinois or the MSA. In contrast, the proportion of very high income households is lower in the Medical Center's service area than in Illinois or the MSA.

Comparison of 2014 Household Income of ACMC/ACH – OL
Primary and Secondary Service Areas with Illinois and Chicago Metropolitan Area

2011 Household Income	Percent Primary Service Area	Percent Secondary Service Area	Percent Total Service Area	Percent Region 7 Trauma	Percent Illinois	Percent MSA Area
< \$15K	11.7	19.6	15.0	13.0	12.3	11.6
\$15 - \$25K	12.0	13.0	12.4	11.6	10.8	10.1
\$25 - \$50K	25.7	23.7	24.9	23.9	23.4	22.2
\$50 - \$75K	18.8	16.6	17.9	18.8	18.3	17.9
\$75 - \$100K	13.0	10.4	11.9	12.8	12.5	12.6
Over \$100K	18.8	16.7	18.0	19.9	22.7	25.6
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source: Truven Market Expert

Healthy habits are strongly connected to physical health, and low-income Americans are less likely to practice healthy behaviors, underscoring the interconnectedness of different aspects of well-being. Low-income Americans are less likely to report healthy eating and frequent exercise compared with those with higher incomes. Smoking is nearly 3 times as common among low-income as among high-income Americans. The Medical Center has a high proportion of population with a household income of \$24,000 per year or less.

Unemployment

The next table compares unemployment in the Medical Center's service area with the State of Illinois and with Chicago's MSA. The unemployment rate across the service area is higher than the State and MSA averages. Gallup-Healthways Well-Being Index data documents the severity of health disparities between low- and high-income Americans. Those making less than \$24,000 per year suffer from much lower emotional and physical health, have poorer health habits, and have significantly less access to medical care – all of which combine to reduce their overall Well-Being Index score.

Comparison of 2014 Unemployment Percentages of ACMC/ACH – OL
Primary and Secondary Service Areas with Illinois and Chicago Metropolitan Area

	Percent Primary Service Area	Percent Secondary Service Area	Percent Total Service Area	Percent Region 7 Trauma	Percent Illinois	Percent MSA Area
Percent of Unemployment	9.7	11.0	10.2	9.7	7.3	8.0

Source: Truven Market Expert

According to the National Institutes of Health, there is reasonably good evidence that unemployment itself is detrimental to health and has an impact on health outcomes – increasing mortality rates, causing physical and mental ill-health and greater use of health services.

Education Achievement

The adult education level of the Medical Center’s service area population is lower than that of Illinois or the MSA, with a higher proportion of the population age 25+ with less than high school or some high school and lower proportions with a college bachelor’s degree or greater. (See the table below.)

Education is strongly linked to health and to determinants of health such as health behaviors, risky contexts and preventative service use. Those with more years of schooling tend to have better health and well-being and healthier behaviors. Education is an important mechanism for enhancing the health and well-being of individuals because it reduces the need for health care, the associated costs of dependence, lost earnings and human suffering. It also helps promote and sustain healthy lifestyles and positive choices, supporting and nurturing human development, human relationships and personal, family and community well-being.

Source: Measuring the effects of education on health and civic engagement: proceedings of the Copenhagen symposium, 2006, www.oecd.org/dataoecd/23/61/37437718.pdf

2014 Comparison of Adult Education Level of ACMC/AHCH’s
Primary and Secondary Service Areas with Illinois and Chicago Metropolitan Area

2011 Adult Education Level	Percent Primary Service Area Age 25+	Percent Secondary Service Area Age 25+	Percent Total Service Area Age 25+	Percent Region 7 Trauma Age 25+	Percent Illinois Age 25+	Percent MSA Area Age 25+
Less than High School	8.7	6.7	7.9	6.8	5.7	6.7
Some High School	9.2	10.2	9.6	8.6	7.3	7.1
High School Degree	31.9	29.1	30.8	30.5	27.5	24.2
Some College/Assoc. Degree	29.4	32.4	30.6	31.6	28.6	26.5
Bachelor’s Degree or Greater	20.8	21.6	21.1	22.6	30.9	35.5
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source: Truven Market Expert

Payor Source

Medicaid patients account for a higher proportion of the Medical Center's payor mix than Illinois; private insurance is somewhat higher and inpatient Medicare is somewhat lower.

The following tables summarize the payor mix of the Medical Center's adult and pediatric payor mix and provide a comparison to the Illinois payor mix. Medicaid patients account for a higher proportion of the Medical Center's payor mix than Illinois; private insurance and managed care is somewhat higher, and inpatient Medicare is somewhat lower.

Inpatient Adult Payor Mix in ACMC/ACH – OL's Primary and Secondary Service Areas, 2013

Primary Service Area		
Insurance	Patients	Percent of Total
Medicaid	18,230	17.4
Self Pay	5,465	5.2
Managed Care	29,783	28.5
Medicare	47,644	45.5
Other	3,528	3.4
Total	104,650	100.0
Secondary Service Area		
Insurance	Patients	Percent of Total
Medicaid	18,782	23.9
Self Pay	5,065	6.5
Managed Care	17,946	22.9
Medicare	34,128	43.5
Other	2,543	3.2
Total	78,464	100.0

Source: IL COMPdata

Inpatient Pediatric Payor Mix in ACMC/ACH – OL's Primary and Secondary Service Areas,
2013

Primary Service Area		
Insurance	Patients	Percent of Total
Medicaid	9,741	49.2
Self Pay	1,549	7.8
Private Insurance/Managed Care	8,349	42.1
Medicare	8	0.0
Other	172	0.9
Total	19,819	100.0
Secondary Service Area		
Insurance	Patients	Percent of Total
Medicaid	8,248	59.7
Self Pay	982	7.1
Private Insurance/Managed Care	4,401	31.9
Medicare	16	0.1
Other	164	1.2
Total	13,811	100.0

Source: IL COMPdata

Illinois Inpatient Payor Mix, 2013

State of Illinois – Inpatient Payor Mix		
Insurance	Patients	Percent of Total
Medicaid	297,683	19.0
Self Pay	48,320	3.1
Private Insurance/Managed Care	466,975	29.8
Medicare	586,903	37.5
Other	165,805	10.6
Total	1,565,686	100.0

Source: IDPH 2013 IL Hospital State Summary

3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]

There are several components to the proposed Project – the Level I Trauma/Resuscitation Center, Emergency Department, Phase I and Phase II recovery stations, inpatient endoscopy, general radiology, as well as other clinical functions.

The problems and issues in each area relate to a shortage of treatment areas and lack of space to function efficiently at current and projected volumes.

Level I Trauma/Resuscitation Center

The Level I Trauma Center currently has four rooms with two treatment stations for a total of 8 stations. This shared space is very unsatisfactory for the care of patients in life-threatening circumstances. When both stations must be used at the same time, it is possible that an adult shooting victim could be in the same space as a patient who had been in an automobile accident. The complications of such a situation are obvious. The current Trauma Center is located in 1,432 DGSF or only 179 DGSF per station including a satellite lab and respiratory therapy.

Emergency Department

The Emergency Department currently has 26 adult and 16 pediatric stations (for a total of 42) located in 21,081 DGSF or 502 DGSF per station. These areas are substantially smaller than the State Agency guideline of 900 DGSF per treatment station. Because the number of treatment stations in the Emergency Department is inadequate to meet current demand, the Medical Center curtained off 18 spaces in the hallways to accommodate patients too sick to remain in the waiting room. These cubicles are small (only 2 feet by 7 feet), are noisy and lack privacy.

Phase I Recovery

The Medical Center currently has 10 Phase I recovery stations for endoscopy and cardiac catheterization patients in an area adjacent to the cardiac cath lab. The number of Phase I recovery stations will not change as part of this Project. (The cardiac catheterization labs are not part of this Project.) However, they will be modernized for greater efficiency.

Phase II Recovery

The Medical Center currently has 9 Phase II recovery stations for cardiac catheterization patients. This number is inadequate to support cardiac cath and endoscopy volume. They, too, require modernization.

Endoscopy Labs

The existing 3 inpatient endoscopy procedure labs are small; are currently located in 1,995 DGSF or 665 DGSF per room compared to the State Agency guideline of 1,100 DGSF per room.

4. Cite the sources of the information provided as documentation.

- Advocate Health and Hospitals Corporation and Advocate Christ Medical Center clinical, administrative, and financial data. Selected data from Advocate Children's Hospital (Oak Lawn)
- Advocate Christ Medical Center's campus master plan
- Other studies performed by external planners, architects and engineers
- National and State of Illinois demographic reports
- Illinois Department of Public Health *Hospital Profiles*
- Health Facilities and Service Review Board Rules
- Health Facilities and Service Review Board standards and guidelines
- Technical Assistance from State Staff
- Region VII EMS System web sites
- Health care literature related to trends in trauma services, emergency services and other clinical services that are included in the project
- *American College of Emergency Physicians, Emergency Room Design (2002)*, Edited by Jon Huddy, AIA
- Health care literature related to the possible implications of the Affordable Care Act
- Illinois Department of Public Hospital Licensing Code
- Illinois and Oak Lawn building, mechanical, electrical and accessibility codes
- IDPH Hospital Licensing Act

5. Detail how the project will address the previously referenced issues, as well as the population health status and well-being.

As noted in the response to 3 above, Advocate Christ Medical Center is faced with very severe space deficits; historically trauma, emergency and recovery areas have been land locked and unable to expand. The current space allocation results in patient access being compromised just as patient satisfaction and operational efficiency are being sacrificed. Lack of space is impeding the Medical Center's ability to serve the residents of south and southwest Chicago and beyond.

The current inadequate number of treatment spaces and very serious space deficits must be addressed in order for the Medical Center to continue to meet high standards of patient care.

The original Emergency Department (before the Medical Center was designated as a Level I Trauma Center) was designed to accommodate 50,000 annual patient visits. In 2013, the Emergency Department had almost 92,000 visits. Annual volumes exceed the number of treatment spaces available to facilitate patient throughput resulting in waiting times between arrival and the time seen by a provider more than 3 times the national average, and frequently as long as 5 hours or more. Due to this severe overcrowding, patients are routinely placed in hallway curtained cubicles without call lights creating issues of safety, privacy, HIPAA compliance, and low patient satisfaction. The rate of patients triaged in the Emergency Department and who left without being treated due to overwhelmingly long wait time is 50 percent higher than the national average. Expansion and modernization of the Emergency Department will help to provide an efficient area to appropriately triage patients, reduce wait times until a patient is seen by a provider, and reduce the extremely high stress levels under which the physicians, nurses and other emergency department staff work.

While patients are complimentary of the care they receive in the Medical Center's Emergency Department, they frequently complain about long wait times due to an inadequate number of treatment stations and crowding because of inadequate space. Typical comments include:

- A great amount of work needs to be done in the ED area for both patient and doctor convenience. Needs to be bigger.
- The wait times in the Emergency Department are RIDICULOUS. I was in the Emergency Department for almost 5 hours before I was treated.
- We were crammed in there (the waiting room) like cattle.
- The waiting room was very cramped.
- 9 hours to wait is ridiculous
- Waited a long time in the waiting room before going to a treatment area because the Emergency Room was very full.
- It was a 9 hour wait to see a doctor. The waiting area was horrifying. No where to sit. People coughing and crying.
- Hallways and walkways were very congested in the ER.

The Level I Trauma/Resuscitation Center was carved out of the original Emergency Department space. In 2013, the Medical Center reported 2,450 trauma visits. The treatment spaces are severely undersized; the rooms are far too small to accommodate staff and equipment needed to treat patients in life-threatening situations. There are currently only 4 trauma rooms, each with 2 beds; consequently not only is there no patient privacy, critically ill and injured patients are subjected to the voices of clinicians and the sounds related to the treatment of another critically ill or injured patient. This patient proximity increases stress in an already very stressful situation.

The Phase I and Phase II recovery stations are used for the treatment of patients with serious cardiac conditions and who are being prepared for or recovering from cardiac catheterization or electrophysiology procedures; although some of these patients are scheduled, many are brought to the area from the Emergency Department because of their life-threatening conditions. The Phase I recovery stations are also used for inpatient endoscopy patients post procedure. The number of Phase II recovery areas are inadequate.

Today, most endoscopy procedures are performed on an outpatient basis; for that reason 7 endoscopy labs have been relocated to the recently opened Ambulatory Pavilion. However, 3 rooms will remain in the hospital to diagnose and treat inpatients requiring endoscopic procedures. The department will remain in its current location because of the proximity to the recovery stations and be enlarged slightly.

The relocation of triage, the cast room and the TEE room to either new space or space vacated when other functions relocated to the Ambulatory Pavilion is being done to improve patient care and efficiency. There are no square footage State Guidelines for these services; the number of rooms, except for triage, will not change however, the square footage will increase modestly to meet clinical and operational requirements.

The proposed Project will address the existing space constraints by modernizing existing and newly vacated space to enlarge and modernize the Trauma Center, the Emergency Department, Phase I and Phase II recovery, the inpatient endoscopy suite, and other smaller clinical functions. This increase in key rooms and expansion of patient care and support space will decrease the space deficit that is causing a wide range of patient care and operational inefficiencies in these areas. The triage area, cast room and TEE room will also be modernized.

Level I Trauma Center

At Project completion, ambulances and other security vehicles will access the department via a reconstructed ramp that will provide direct access to the trauma area. The number of trauma rooms will increase from 8 to 12; of the total, two will be oriented to the specific needs of pediatric trauma patients. Each of the rooms will be private thereby alleviating the negative impact of having two stations in one room. The square footage of the area will increase from 1,472 DGSF to 7,294 DGSF or to 608 DGSF per station, allowing adequate space for the physicians and nurses, equipment and support functions.

Emergency Department

In the proposed expanded and modernized Emergency Department, there will be areas for pediatric and adult patients. Each area will have its own clinical team, waiting, triage, and other functions to meet the unique needs of pediatric and adult patients. The adult area will have 5 secure behavioral health stations; all rooms will be capable of meeting the special needs of geriatric patients. However, because of seasonality, especially of pediatric patients, some of the rooms will have the ability to flex to accommodate either peak pediatric or peak adult census. Further, there will be 2 general radiography units in the department to expedite imaging studies. Finally, all of the curtained cubicles will be eliminated.

Phase I Recovery Area

The expanded and modernized Phase I recovery area to be used by cardiac cath and endoscopy patients will have 10 bays; enough rooms to adequately support the volume of post procedure patients. The overall space per bay will be 175 DGSF and will provide space for physicians and nurses who are monitoring the patients' progress as they regain consciousness after their procedure and before they are either discharged home or admitted to a bed.

Phase II Prep/Recovery

Patients will be seen in the Phase II Prep/Recovery Area adjacent to the cath labs and the endoscopy procedure rooms prior to their procedure. The number of rooms will be increased from 9 to 21 to better accommodate both scheduled and unscheduled catheterization patients. The space per Phase II recovery station will increase to 390 DGSF to allow for more patient care space as well as staff and other support space. Increased space will add to improved work flow and staff efficiency as well as provide patient privacy and space for families.

Inpatient Endoscopy

Consistent with the plans outlined in the Ambulatory Pavilion application (Permit #11-019) inpatient endoscopy procedures will remain in the hospital. At the conclusion of the project, inpatient endoscopy will be right-sized to 3 procedure rooms and the square footage will increase to 891 DGSF per room or consistent with the State Agency guideline of 1,100 DGSF per room. Patients will be prepped and await their procedure in comfortably sized Phase II prep/recovery bays until they are taken to the procedure area; they will be returned to Phase I recovery until they are able to be either discharged or admitted.

Triage, Cast Room and TEE Room

Triage, the cast room and the TEE room will be relocated to available updated space and conservatively sized to meet clinical and support requirements.

6. *Provide goals with quantified and measurable objectives, with specific timeframes that related to achieving the stated goals **as appropriate.***

The fundamental goal of the Project is to improve access to the existing adult and pediatric Level I Trauma/Resuscitation Center and Emergency Department at Advocate Christ Medical Center. The following objectives are related to achieving this goal.

Objective 1

Expand and modernize ACMC's Level I Adult and Pediatric Trauma/Resuscitation Center in order to have 12 private treatment rooms with adequate space to treat incoming patients in life-threatening conditions. This objective is expected to be achieved in the first quarter of 2020.

Objective 2

Expand and modernize ACMC's Adult and Pediatric Emergency Department in order to provide 70 private treatment stations (18 for pediatric patients and 52 for adult patients) with adequate space both to treat patients requiring emergency care and to be operationally efficient. This will be achieved by adding 2 pediatric stations and 26 adult stations and eliminating all temporary curtained cubicles, increasing the department from 16,348 DGSF to 24,093 DGSF. The Emergency Department design will provide flexibility for seasonality related to emergency patients. This objective is expected to be achieved by the first quarter of 2020.

Of the additional adult stations, 18 will replace curtained cubicles; therefore the net addition is 10 emergency stations.

Objective 3

Provide 42 stations (included in the proposed 70) in the Emergency Department to meet the unique needs special adult populations. To achieve this goal, 5 stations will be designed and equipped to meet the needs of behavior health patients and all will have features that meet the special needs of geriatric patients. This objective is expected to be achieved in the first quarter of 2020.

Objective 4

Substantially reduce wait times for pediatric and adult patients to see a health care professional from the current 81 minutes to 17 minutes. This will be achieved by having an adequate number of treatment areas to accommodate the high volume of emergency patients and to improve the work flow including a new triage area at ground level. As part of the objective, the new triage and treatment areas will be partially completed by the first quarter of 2020.

Objective 5

Reuse existing trauma, emergency, and vacated space to address high priority facility needs at the Medical Center. This will be accomplished by expanding and modernizing the Trauma Center and the Emergency Department as well as expanding and modernizing Phase I and Phase II recovery areas and inpatient endoscopy. This objective is expected to be achieved by the first quarter of 2020.

Objective 6

Enhance the ability to provide necessary space for other features of the Trauma Center and the Emergency Department such as graduate medical education, research, Emergency Preparedness, and EMT support. This objective is expected to be achieved by the second quarter of 2020.

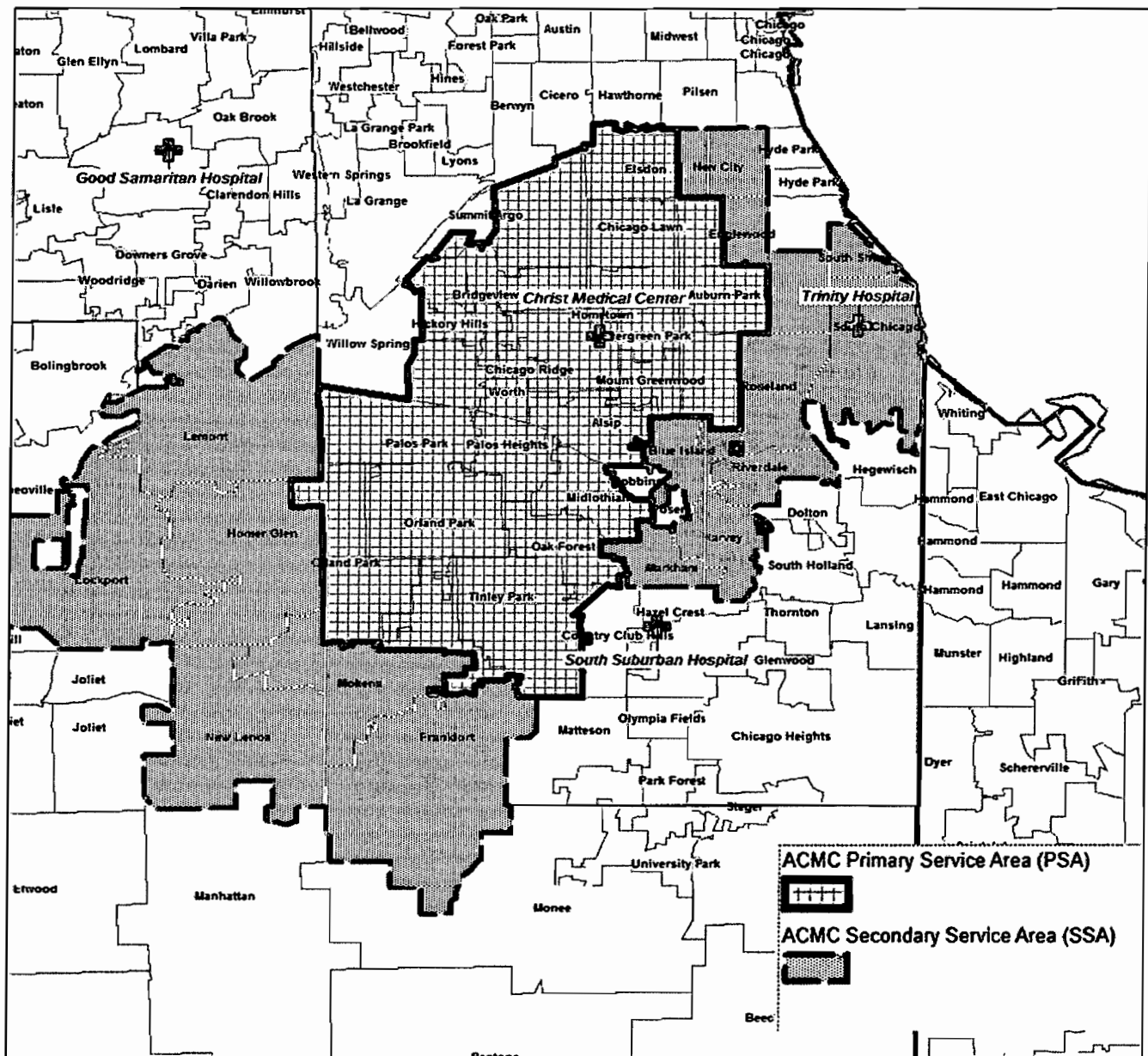
Trauma Center and
Emergency Department
Patient Origin 2013

ACMC Service Area	Patient Zip Code	Adult Trauma I	Pediatric Trauma I	Adult Emergency	Pediatric Emergency
PSA	60453	71	6	8,489	2,799
	60629	94	8	4,394	3,773
	60652	51	3	4,043	2,350
	60620	105	24	3,784	1,514
	60459	30	2	3,770	1,371
	60643	59	16	2,566	998
	60638	51	1	1,872	1,034
	60415	19	2	2,058	858
	60455	26	2	2,093	740
	60803	27	4	1,941	819
	60655	31	1	1,530	780
	60805	18	2	1,562	701
	60632	17	3	1,039	892
	60636	62	6	1,252	436
	60458	25	1	1,045	560
	60457	16	1	1,110	482
	60445	22	2	890	443
	60482	17	1	796	392
	60465	18	2	761	422
	60456	5	2	797	281
	60477	23	5	558	388
	60452	19	2	493	410
	60462	17	5	555	281
	60463	18	2	603	118
	60487	8	2	198	180
	60467	9	-	184	92
	60464	6	1	165	51
PSA Total		864	106	48,548	23,165
SSA	60628	152	18	2,499	1,072
	60619	101	12	1,233	350
	60617	104	12	949	547
	60406	30	7	567	635
	60621	31	4	586	206
	60827	41	7	447	258
	60609	17	-	447	198
	60649	33	1	300	110
	60426	50	7	187	172
	60423	7	-	109	121
	60428	14	1	97	85
	60448	2	-	113	67
	60491	-	-	90	54
	60441	3	2	82	45
	60451	2	1	67	49
	60439	4	1	80	18
SSA Total		591	73	7,853	3,987
Other Illinois		493	72	5,325	3,106
Other States		217	15	816	320
Other Total		1	-	41	3

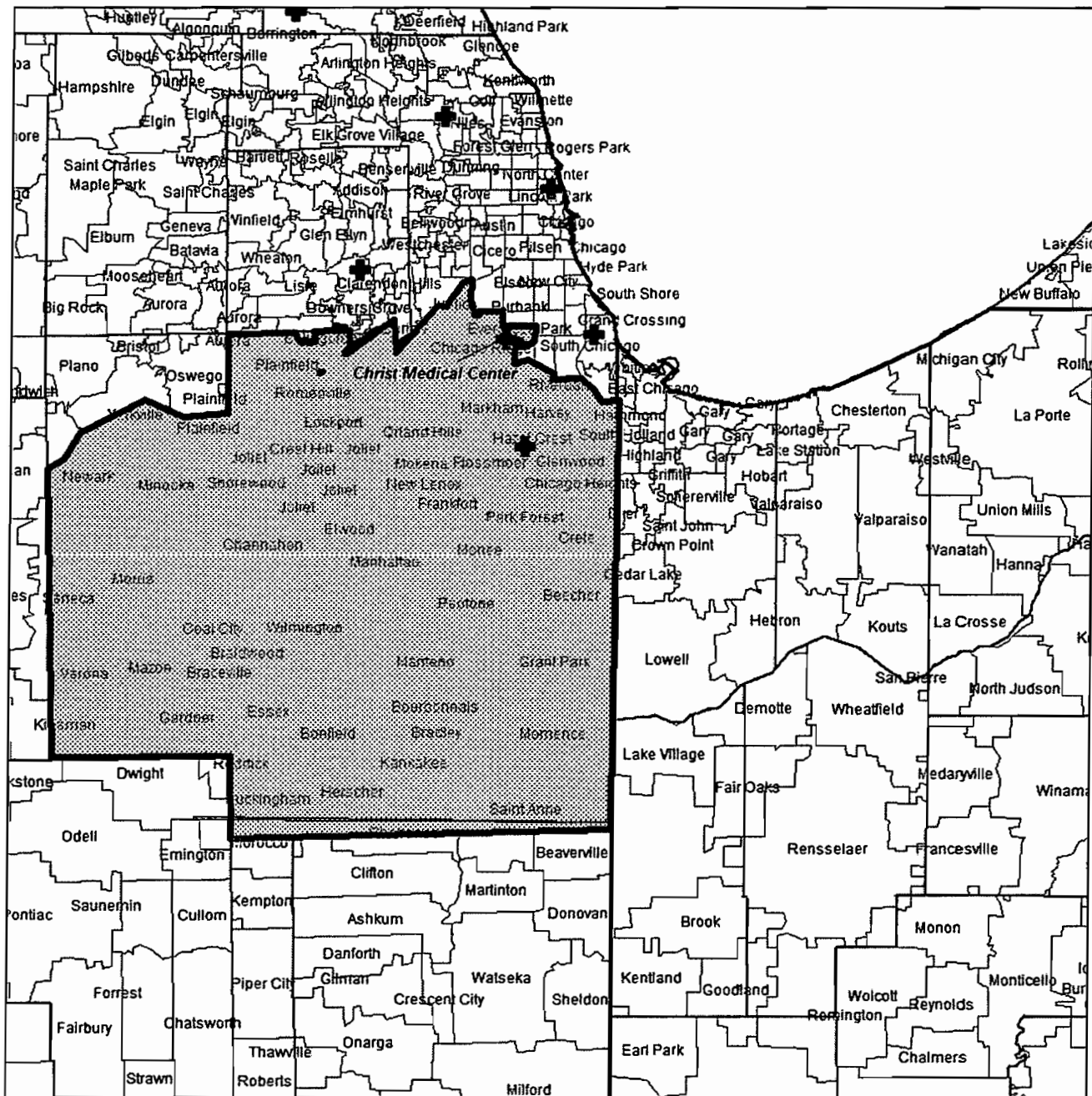
Source: Medical Center Financial Records (TSI System)

Note: Data for this table was derived from a different source than was the utilization reported in the AHQ.

Advocate Christ Medical Center Primary and Secondary Service Areas, 2013



Map of EMS System Region VII



Advocate Christ Medical Center
Primary and Secondary Service Area Population, 2014

Service Area	ZIP Code	ZIP City Name	Population				
			Population	Total <15	Total 15-44	Total 45-64	Total 65+
PSA	60415	Chicago Ridge	14,555	2,962	6,123	3,584	1,886
PSA	60445	Midlothian	26,434	4,815	10,293	7,264	4,062
PSA	60452	Oak Forest	28,212	5,268	11,275	8,116	3,553
PSA	60453	Oak Lawn	57,514	10,078	21,340	15,614	10,482
PSA	60455	Bridgeview	16,883	3,481	6,572	4,461	2,369
PSA	60456	Hometown	4,449	755	1,746	1,224	724
PSA	60457	Hickory Hills	14,108	2,498	5,591	3,918	2,101
PSA	60458	Justice	15,157	3,434	6,541	3,725	1,457
PSA	60459	Burbank	29,513	5,750	11,971	7,744	4,048
PSA	60462	Orland Park	40,079	6,159	13,723	12,258	7,939
PSA	60463	Palos Heights	14,587	1,970	4,396	4,263	3,958
PSA	60464	Palos Park	10,060	1,345	2,763	3,249	2,703
PSA	60465	Palos Hills	17,812	2,764	6,727	5,013	3,308
PSA	60467	Orland Park	27,232	4,501	8,797	8,827	5,107
PSA	60477	Tinley Park	39,787	6,736	15,149	11,517	6,385
PSA	60482	Worth	11,172	2,043	4,477	3,191	1,461
PSA	60487	Tinley Park	26,800	5,255	10,223	8,321	3,001
PSA	60620	Chicago	71,680	13,763	27,696	18,437	11,784
PSA	60629	Chicago	114,350	29,927	52,648	23,423	8,352
PSA	60632	Chicago	91,164	24,687	42,571	17,599	6,307
PSA	60636	Chicago	39,877	9,066	16,646	9,184	4,981
PSA	60638	Chicago	55,827	11,052	22,250	14,517	8,008
PSA	60643	Chicago	49,895	8,969	17,903	14,220	8,803
PSA	60652	Chicago	41,221	9,165	17,154	10,750	4,152
PSA	60655	Chicago	28,041	5,713	11,200	7,931	3,197
PSA	60803	Alsip	23,012	4,413	9,320	6,182	3,097
PSA	60805	Evergreen Park	19,953	3,782	7,713	5,789	2,669
Primary Service Area Subtotal			929,374	190,351	372,808	240,321	125,894

Advocate Christ Medical Center
Primary and Secondary Service Area Population, 2014

			Population				
Service Area	ZIP Code	ZIP City Name	Population	Total <15	Total 15-44	Total 45-64	Total 65+
SSA	60406	Blue Island	25,832	6,350	11,171	6,023	2,288
SSA	60423	Frankfort	31,394	6,593	11,042	9,820	3,939
SSA	60426	Harvey	29,193	7,156	12,236	6,432	3,369
SSA	60428	Markham	12,493	2,739	5,164	2,970	1,620
SSA	60439	Lemont	23,640	4,033	7,920	7,729	3,958
SSA	60441	Lockport	36,917	7,463	16,024	9,570	3,860
SSA	60448	Mokena	24,362	4,629	8,858	7,932	2,943
SSA	60451	New Lenox	34,009	7,357	12,943	10,151	3,558
SSA	60491	Homer Glen	22,961	4,257	8,105	7,576	3,023
SSA	60609	Chicago	65,107	16,660	29,681	13,493	5,273
SSA	60617	Chicago	83,232	18,064	33,047	20,002	12,119
SSA	60619	Chicago	62,640	11,225	22,949	17,675	10,791
SSA	60621	Chicago	34,457	8,122	14,406	7,892	4,037
SSA	60628	Chicago	70,494	14,213	27,575	17,414	11,292
SSA	60649	Chicago	46,414	8,667	18,311	12,801	6,635
SSA	60827	Riverdale	28,052	6,869	12,019	6,587	2,577
Secondary Service Area Subtotal			631,197	134,397	251,451	164,067	81,282
Total (PSA & SSA)			1,560,571	324,748	624,259	404,388	207,176

Source: Truven, Claritas

Advocate Christ Medical Center
Primary and Secondary Service Area Population, 2024

Service Area	ZIP Code	ZIP City Name	Population				
			Population	Total <15	Total 15-44	Total 45-64	Total 65+
PSA	60415	Chicago Ridge	14,723	3,105	5,966	3,567	2,085
PSA	60445	Midlothian	27,470	4,925	10,523	7,285	4,737
PSA	60452	Oak Forest	28,821	5,233	11,276	7,992	4,321
PSA	60453	Oak Lawn	59,192	10,268	22,010	15,317	11,598
PSA	60455	Bridgeview	17,846	3,635	6,903	4,498	2,810
PSA	60456	Hometown	4,539	717	1,772	1,242	808
PSA	60457	Hickory Hills	14,412	2,568	5,599	3,807	2,437
PSA	60458	Justice	16,922	3,818	7,117	3,994	1,993
PSA	60459	Burbank	30,526	5,861	12,275	7,753	4,637
PSA	60462	Orland Park	41,249	6,124	14,334	11,563	9,229
PSA	60463	Palos Heights	15,063	1,955	4,738	3,929	4,441
PSA	60464	Palos Park	11,097	1,432	3,137	3,172	3,357
PSA	60465	Palos Hills	18,470	2,933	6,793	4,852	3,892
PSA	60467	Orland Park	30,077	4,340	10,168	9,053	6,516
PSA	60477	Tinley Park	41,595	7,090	15,572	11,282	7,651
PSA	60482	Worth	11,314	2,110	4,399	3,143	1,662
PSA	60487	Tinley Park	28,680	5,108	10,864	8,743	3,964
PSA	60620	Chicago	70,680	13,214	27,331	17,707	12,427
PSA	60629	Chicago	115,925	29,195	52,011	24,757	9,963
PSA	60632	Chicago	92,118	24,026	41,578	19,163	7,352
PSA	60636	Chicago	37,279	8,287	15,839	8,203	4,949
PSA	60638	Chicago	57,292	11,165	22,339	14,826	8,963
PSA	60643	Chicago	49,195	8,368	17,815	13,318	9,695
PSA	60652	Chicago	42,556	8,833	17,571	11,075	5,077
PSA	60655	Chicago	28,284	5,653	11,032	7,811	3,787
PSA	60803	Alsip	24,007	4,581	9,522	6,226	3,677
PSA	60805	Evergreen Park	19,861	3,597	7,679	5,530	3,055
Primary Service Area Subtotal			949,194	188,138	376,165	239,807	145,084

Advocate Christ Medical Center
Primary and Secondary Service Area Population, 2024

			Population				
Service Area	ZIP Code	ZIP City Name	Population	Total <15	Total 15-44	Total 45-64	Total 65+
SSA	60406	Blue Island	25,758	6,138	10,967	6,032	2,620
SSA	60423	Frankfort	32,396	6,068	11,281	10,081	4,966
SSA	60426	Harvey	28,322	6,650	11,950	6,145	3,576
SSA	60428	Markham	12,910	2,640	5,421	3,025	1,824
SSA	60439	Lemont	25,716	3,917	8,853	7,975	4,971
SSA	60441	Lockport	37,602	7,188	15,837	10,088	4,489
SSA	60448	Mokena	24,848	4,111	9,240	7,716	3,781
SSA	60451	New Lenox	34,642	6,589	13,157	10,418	4,478
SSA	60491	Homer Glen	22,424	3,706	8,029	7,008	3,681
SSA	60609	Chicago	64,949	15,915	28,881	14,002	6,152
SSA	60617	Chicago	81,471	17,078	32,295	19,106	12,992
SSA	60619	Chicago	60,177	10,539	22,000	16,134	11,503
SSA	60621	Chicago	31,432	7,240	13,362	6,846	3,985
SSA	60628	Chicago	67,520	13,234	26,420	16,121	11,745
SSA	60649	Chicago	45,606	8,502	17,526	12,089	7,488
SSA	60827	Riverdale	28,919	6,670	12,390	6,649	3,209
Secondary Service Area Subtotal			624,692	126,186	247,610	159,435	91,461
Total			1,573,886	314,324	623,774	399,243	236,545

Source: Truven, Claritas

ALTERNATIVES

- 1) Identify **ALL** of the alternatives to the proposed project:

Alternative options **must** include:

- A) Proposing a project of greater or lesser scope and cost;
 - B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;
 - C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and
 - D) Provide the reasons why the chosen alternative was selected.
- 2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**
 - 3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

APPEND DOCUMENTATION AS ATTACHMENT-13. IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Advocate Christ Medical Center (ACMC, Medical Center) is proposing to expand and modernize several clinical service areas including the Level I Trauma/Resuscitation Center (Trauma Center), the Emergency Department, general radiography (to support the trauma and emergency areas), inpatient endoscopy, Phase I and Phase II recovery (to support cardiac catheterization and endoscopy) as well as triage, a cast room, and transesophageal echo (TEE).

A) Proposing a Project of Greater or Lesser Scope

The Medical Center completed a campus-wide master planning initiative in early 2011 and immediately began to implement the approved master plan. In March 2014 the Ambulatory Pavilion (Permit # 11-019) was opened; a new patient tower (Permit # 12-066) is currently under construction with completion targeted for July 2019.

The proposed Project is the third major phase of the campus master plan and the subject of this application. Trauma and emergency services have been at the forefront of the master planning initiatives throughout the process and at least six major alternatives for the redevelopment of these services have been considered; a description of each and the rationale for accepting the alternative of choice and rejecting all others follows.

An ACMC campus map is included as Attachment 13, Exhibit 1 to identify the locations of the alternatives that were considered on the Medical Center's campus.

Alternative 1 – Expand Trauma/Emergency Services as the First Phase of the Master Planning Initiative

Early in the master planning process, Alternative 1 was considered; it envisioned redeveloping the trauma and emergency services as the first implementation phase of the master plan. The community hospital that had opened more than 50 years before had become a center of advanced medicine and surgery with the only Level I Trauma Center in Health Planning Area A-04 and in EMS System Region VII. Over the years, trauma and emergency volumes experienced strong growth; however, no major expansion of these services occurred during the last 25 years to accommodate the expanded role of the Medical Center as a tertiary/quaternary referral center in Chicago's southwest suburbs including trauma/emergency services.

At first, this appeared to be an attractive option; however, it was soon rejected. The existing bed complement was experiencing strong utilization and was hampered in its ability to accommodate growth because of limitations such as inadequate numbers of intensive care and medical surgical beds and a high percentage of multi-occupancy rooms. Approximately 25 percent of the Medical Center's trauma and emergency visits result in an admission (compared to 16 percent statewide). When the high percentage of admissions from the trauma/emergency areas was put in the context of the already high bed occupancy, it was clear that expanding the trauma and emergency services before more beds were available would further exacerbate the already high occupancy of available beds, cause the emergency services to go on bypass more often, increase already long waiting times for emergency care and otherwise be unavailable to the community.

Although lack of beds to accommodate an increasing number of trauma and emergency patients was an important reason for rejecting this alternative, there was also a second one. ACMC is located on a site that has limited expansion capabilities but is well located to serve its market and represents a capital investment too large to totally replace on another larger site. Hence, the master campus plan had to diligently consider the highest and best use of each available land parcel on the campus. Since a new bed tower and an ambulatory pavilion were also being considered as part of the master plan, the planning team was reluctant to immediately start a trauma and emergency expansion only to learn later that it had been located on the most ideal site for either the bed tower or the ambulatory pavilion projects.

Hence, this option was rejected. However, the Medical Center began to introduce interim solutions to better serve the community until the trauma / emergency service could be redeveloped. The staff initiated improved patient flow processes and created temporary "curtained cubicles" in the hallways for patients who required immediate attention when trauma/emergency stations were fully occupied with other patients. The cost of this alternative was \$24,000.

Alternative 2 – Relocate the Trauma and Emergency Services across the Street from the Main Campus

Although the campus is very constrained, the campus master planners considered a potential expansion site across South Kilbourn Avenue; the site is owned by the Medical Center and currently used as surface parking.

Again, this alternative was rejected because it was impractical. To build new trauma and emergency departments on the parking lot would have required that a bridge be built across South Kilbourn Avenue. This bridge was necessary to transport patients between the trauma and emergency services and the other clinical hospital services frequently used by trauma and emergency patients; even with a bridge some services would need to be duplicated in the remote department on the parking lot site. For some services frequently needed by trauma and emergency patients, such as general radiography and laboratory, duplication of staff and technology was not insurmountable but for others replication would have been very costly. Further, parking spaces eliminated by the construction of a new trauma and emergency service would need to be replaced, most likely by constructing a parking structure that would add cost to the project. Because this was not a feasible option, no cost was developed.

Alternative 3 – Develop a Pediatric Emergency Department and Connect It to Advocate Children's Hospital

Advocate Children's Hospital – Oak Lawn is located on the Advocate Christ Medical Center campus. Currently, pediatric trauma and emergency patients are treated in the Medical Center and account for approximately 30 percent of the total patients. The third alternative considered constructing a separate pediatric trauma and emergency service and connecting it to the Children's Hospital. Although this option was very attractive because it would provide a distinct pediatric area in immediate proximity to the Children's Hospital and because it would relocate a large number of patients from the trauma and emergency service in the Medical Center, it also

was rejected for several reasons. First, having two trauma and emergency departments on the same campus would require costly duplication of services with not only attendant short-term capital costs but also with ongoing operational costs. Further, the professional planners did not recommend two separate services because two departments on the same campus would confuse patients and families who were both in stressful situations and trying to find the correct facility quickly. Since this alternative was not feasible, no cost was developed.

Alternative 4 – Develop a Freestanding Emergency Center in Orland Park/Tinley Park

A fourth consideration was to develop a freestanding emergency center on the site of the Advocate Medical Campus. This campus spans the borders of Orland Park and Tinley Park. Again, this option appeared to have merits because it could decompress volume in emergency service at the Medical Center. After thorough analysis, this option was rejected. A remote freestanding emergency center would not have the same capabilities as the trauma and emergency services at ACMC in Oak Lawn, but rather would be more like an emergency department in a community hospital. While this alternative would potentially relieve the Emergency Department at the Medical Center of lower acuity cases and enable faster treatment for more acutely ill patients, it had substantial disadvantages. First, the Medical Center does not treat a high percentage of lower acuity patients, so the impact of these patients being seen in Orland Park/Tinley Park on the main Medical Center trauma and emergency services would be minimal. Further, the Orland Park/Tinley Park area is not part of the Medical Center's core service area so while a freestanding emergency center would provide convenient care to low acuity patients in Orland Park/Tinley Park, it would not be serving the Medical Center's core community and would therefore have only minimal impact on volume at the main Trauma Center and Emergency Department and would not resolve pressing need for more capacity on the campus. The cost of building a freestanding emergency center in Orland Park/Tinley Park in 2009 was \$26,311,540. With inflation today, the cost would be \$30,258,271.

Alternative 5 – Expand the Existing Emergency Department in Existing Vacated Space

Both the Ambulatory Pavilion permit issued in 2011 and the Inpatient Tower Permit in 2012 included the relocation of several departments from the current hospital building to the new buildings. In 2012, an architect was retained to develop a "Ground and First Floor Back Fill Master Plan" for the Medical Center. (The Trauma Center/Emergency Department is currently on the first floor of the hospital). The Back Fill Master Plan project studied capacity and space needs following the completion of the Ambulatory Pavilion and the Inpatient Tower with the

relocation of selected diagnostic, treatment and support services to the new buildings. After a thorough assessment, the architects determined that there would not be enough existing and vacated space to accommodate the space program for the trauma and emergency departments. To meet the space program requirements, they developed a substantially more aggressive project which included relocating and increasing the number of cardiac catheterization labs and the related recovery spaces and imaging services to the ground level. Although this alternative had many attractive features, it substantially exceeded the budget that had been set for the Trauma Center and Emergency Department project. For these reasons, Alternative 5 was rejected. The estimated cost of Alternative 5 was \$149,989,683.

Alternative 6 – Expand the Trauma and Emergency Services in Existing and New Space

In order to accommodate the space program for the trauma and emergency services, the architects began to look for additional space that would provide the needed square footage that, in conjunction with the existing space, would meet the square footage requirements of the Trauma Center/Emergency Department space program. Two options were identified. The first was to the west of the existing trauma and emergency services in the area of the ramp used by emergency vehicles to access the trauma service; the second was the existing physician parking garage on the ground floor of the surgical pavilion which is due north of the trauma and emergency services location.

After much iteration, the architects determined that the physician parking garage was the best option to provide additional square footage. They determined that physician parking expansion space would be very suitable for a new emergency walk-in triage area at the ground floor level with direct access via stairway and elevator to the first floor where the remainder of the trauma and emergency services could be redeveloped. In addition, there is space that was vacated when services were relocated to the Ambulatory Pavilion and Inpatient Tower that could also become expansion space for the Emergency Department. As an added benefit, the vacated space along with the reassignment of the physician parking could also accommodate the needed expansion of inpatient endoscopy as well as Phase I and Phase II recovery rooms that are used by both endoscopy and cardiac catheterization patients.

Alternative 6 is the alternative of choice for many reasons:

- Increased Patient Safety
 - Separate drop off entrances at different levels for ambulance/security vehicles and walk in patients will make access to the Level I Trauma/Resuscitation Center and the Emergency Department safer.

- All exam rooms will follow the same design standards; this design feature is known to reduce errors.
- Improved adjacency of key departments will reduce transfer time and makes it easier for staffing the Emergency Department.
- There will be adequate work areas to document care; this design concept has been shown to improve quality and safety.
- There will be 2 general radiology units and mobile ultrasound in the trauma and emergency services area; patients will not have to travel to other departments or equipment will not have to be moved to perform imaging services, thus reducing diagnosis and treatment times and also making it safer for the patients.
- Increased Patient Satisfaction and Privacy
 - Wait times will be substantially reduced for pediatric and adult patients to see a health care professional.
 - Expanding space will allow for the creation of private trauma rooms and emergency bays, eliminate curtained cart cubicles in the hallways, and increase overall clinical support space.
- Enhanced Infection Control
 - All exam rooms will be private in order to reduce the spread of infection.
 - The pediatric area will have the capability of being isolated to reduce the spread of infection.
- Improved Operational Efficiency
 - Increased space will add to improved work flow and staff efficiency as well as provide patient privacy and space for families.
 - Visual obstructions including wooden doors will be eliminated to improve patient visibility.
 - The modernized unit will be able to accommodate surges in utilization and mass casualties.
 - Improved triage at the walk-in entrance will permit care to begin immediately with a provider.

- Ability to Better Serve the Community and the Region
 - All exam rooms will be private not only to ensure compliance with HIPAA, but also to reduce noise; noise detracts from maintaining environment
 - Pediatric patients will be separated from the adult patients. Pediatric patients are more likely to cry and be disruptive to the adult population.
 - Behavior health patients will be in a discrete area; these patients are also often disruptive and have the potential to injure staff and other patients
 - The creation of space that can be adapted rapidly for the unique needs of the geriatric population. Geriatric patients will be clustered in a quiet, low traffic treatment area with special lighting and other features that are especially helpful for these patients.

The project cost for Alternative 6 is \$85,519,082. This amount is consistent with the Project budget.

B) Pursuing a Joint Venture or Similar Arrangement

Advocate Christ Medical Center did not consider joint venturing with other area providers to redevelop the trauma and emergency services. The trauma and emergency services operate as part of the premises licensed under the Hospital Licensing Act. Consequently, a joint venture would need to involve a joint venture of the entire Medical Center, and this is not a feasible arrangement.

C) Utilizing Other Health Care Resources that Are Available to Serve All or a Portion of the Population to Be Served By the Project

Advocate Christ Medical Center is the only adult and pediatric Level I Trauma Center in Region 7 (See Attachment 13, Exhibit 2) and Advocate Children's Hospital – OL is the only Children's Hospital in the southwest Chicago suburbs. Other local hospitals have neither the same trauma nor emergency capabilities nor do they have the highly trained staff and technology that are always available and in readiness to accept patients at APMC.

APMC supports a large graduate medical education program that trains emergency medical residents and other students. The continuity of these programs depends on having patients with certain injury/disease status present to meet the educational requirements of their respective specialties. If other facilities were to be used for APMC's trauma/emergency patients, the extensive, needed educational programs at the Medical Center would be compromised.

ACMC also considered the evolving role of Trauma Centers and Emergency Departments (See Attachment 34) as well as implications of the Affordable Care Act and the shortage of primary care physicians in the area. In addition, the Medical Center knows that 70 percent of ACMC's trauma and emergency patients are either urgent or trauma and the alternative intermediate care delivery options that are being developed will not affect volume at the Medical Center. Further, the Medical Center will continue to be a safety net for the uninsured and underinsured in the area. Based on these considerations, utilizing other resources for even a portion of the population to be served by the project did not appear to be a viable option.

Alternative	Total Project Cost	Rationale
1. Expand Trauma and Emergency Services as the First Phase of the Master Planning Initiative	Interim solution \$24,000	Rejected for the following reasons: • Additional trauma and emergency admissions would exacerbate the already high occupancy of beds • High bed occupancy would cause emergency services to go on by-pass more frequently • High bed occupancy would Increase already long wait times for emergency care and otherwise be unavailable to the community • Highest and best use for limited available space on Advocate Christ Medical Center's campus had not yet been determined
2. Relocate the Trauma and Emergency Services across the Street from the Main Campus	Not a feasible option. No cost developed.	Rejected for the following reasons: • Would require a bridge to transport patients from the trauma and emergency services to the beds and ancillary service in the main hospital building • Parking space eliminated by the relocated trauma and emergency services would need to be replaced with a costly parking structure
3. Develop a Pediatric Emergency Department and Connect It to Advocate Children's Hospital (Oak Lawn)	Not a feasible option. No cost developed.	Rejected for the following reasons: • Having two trauma centers and emergency departments on the same campus would require costly duplication of services and attendant short-term capital costs and ongoing operational costs • Have duplicate centers and departments on the same campus would be confusing to patients
4. Develop a Freestanding Emergency Center in Orland Park	\$30,258,271 (Cost inflated to present)	Rejected for the following reason: • Would not relieve resolve the need for more capacity on the Oak Lawn campus
5. Expand the Existing Emergency Department in Existing Vacated Space	\$149,989,683	Rejected for the following reason: • The cost substantially exceeded the budget.
6. Expand the Trauma and Emergency Services in Existing and New Space	\$85,319,082	Alternative of choice for the following reasons: • Increased patient safety • Increased patient satisfaction and privacy • Enhanced infection control • Improved operational efficiency • Ability to better serve the community and the region • Consistent with the Project budget

- 3) *The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care as available.*

National Recognitions for Exceptional Quality of Care

Advocate Christ Medical Center (ACMC, Medical Center) is nationally recognized for the exceptional quality of care it provides. Among recent acknowledgments are the following:

- One of only 7 n hospitals in Illinois recognized by Truven Health as a 100 Top Hospital.
- Ranked by *U.S. News and World Report* as among the top 50 hospitals in the nation for cardiology/heart surgery, gynecology, and neurology/neurosurgery 2014 – 2015.
- More than 90 physicians rated among the country's best in their fields by *U.S. News and World Report* and Castle Connolly Medical Ltd.
- Recognized as a top-performing hospital in the ACS MIDAS+ Platinum Quality Award Program and ranked in the top 5 percent of more than 650 hospitals reviewed by ACS MIDAS+.
- Quality Achievement Award for excellence in treating stroke patients by the American Stroke Association.
- Designated a Blue Distinction Center for spine surgery and knee and hip replacement by BlueCross Blue Shield of Illinois.
- Recognized as a Breast Imaging Center of Excellence by the American College of Radiology.
- Presented a Stroke Gold Plus Quality Achievement Award for excellence in treating stroke patients by the American Heart Association/American Stroke Association.
- Re-designated by the American Nurses Credentialing Center as a Magnet Medical Center.

Further confirmation of excellence in patient care includes:

- Accredited by The Joint Commission and the recipient of disease specific care certification in the treatment of congestive heart failure, stroke, and the implantation of specialized mechanical heart pumps (VADs).
- Awarded three-year re-accreditation for commendation for the Cancer Institute by the Commission on Cancer of the American College of Surgeons.

- Accredited by CARF (Commission on Accreditation of Rehabilitation Facilities) for its 37-bed acute rehabilitation program.
- Accredited by the American College of Surgeons as an approved Teaching Hospital Cancer Program.
- First in the nation to achieve Advanced Heart Failure certification from the Joint Commission.
- Accredited by The Joint Commission as a Primary Stroke Center.
- One of the top five hospitals nationally for VAD surgeries and one of the first sites in the nation to achieve The Joint Commission re-certification in the use of VADs
- Recipient of five Beacon Awards for excellence in critical care by the American Association of Critical Care Nurses.

Quality Features of the Trauma Center/Emergency Department Modernization Project

Advocate Christ Medical Center is committed to delivering safe, quality care to all patients. Safety and quality assurance have been primary considerations in the modernization of the Trauma/Resuscitation Center and the Emergency Department. The modernized facility will meet all applicable codes and regulations, in particular as required by IDPH which bases its licensing criteria on applicable Facility Guidelines Institute guidelines, which in and of themselves are based on research to ensure that quality and safety principles are met.

Example of Improving Quality of Care in the Emergency Department

In 2013, the leadership team at ACMC began to look at opportunities to improve quality of care in the emergency room. One case example was presented of a 95 year old woman who needed to wait in the emergency room for 28 hours until a bed became available.

This event prompted leadership to look at opportunities to positively impact patient care of the senior population. What they discovered was that 18 percent of patients utilizing the emergency room were over the age of 65 and 4 percent of these patients left without being seen. The average time for a senior to be seen by a provider was 95 minutes and overall patient satisfaction was at the 62nd percentile.

According to the American Geriatric Society, by providing appropriate resources to these patients, better patient outcomes will follow: fewer patient falls, fewer injuries, fewer visits to the emergency department and fewer hospital readmissions.

The team set an overall goal to decrease the door to provider time to 67 minutes, reduce left without being seen to 2 percent and increase overall patient satisfaction to 80 percent in the 65 year old plus population.

The first step to achieve these goals was to set up a geriatric track in the Emergency Department. This involved creating a designated space. Having a designated space allowed for a quiet, low traffic treatment area where all patients 65 years and older with an acuity level of 3, 4 and 5 could be directed and visited immediately by a provider.

The team also created a geriatric friendly environment by adding such things as hand rails in the hallways, hearing headsets, assisted ambulatory devices (canes, walkers and wheelchairs), new patient carts equipped with bed alarms for fall prevention and magnified sheets for reading instructions.

In addition to the changes in the environment, the team developed a geriatric needs assessment. This document identifies special needs of the geriatric patient – living alone, need for caregiver, history of falls, weight gain or loss of 10 pounds in the last three months, comfort with medication management, access to food and transportation and ability to perform activities of daily living. If any of these needs are identified, emergency staff members partner with pharmacies and care managers to get the patient the appropriate services needed for a safe transition to home.

With a successful trial, ACMC is planning to maintain its geriatric focus and continuously improve efforts to take care of this growing population. Future space plans will add non-slip flooring, dimmer lights in all rooms, diurnal lighting to maintain orientation (day vs night), sound proofing and raised toilet seats.

SECTION IV - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative.**
2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following:
 - a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;
 - b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;
 - c. The project involves the conversion of existing space that results in excess square footage.

Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?

APPEND DOCUMENTATION AS ATTACHMENT-14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SIZE OF PROJECT:

1. *Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative.***

The square footage of each department/ service in the Project that has a State Standard is below the State Standard. Advocate Christ Medical Center's proposed Project is in compliance with each relevant square footage State Standard.

2. *If the gross square footage exceeds the BGSF or the DGSF standards in Appendix B, justify the discrepancy by documenting one of the following:*
 - a. *Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies.*
 - b. *The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size that exceeding the standards in Appendix B.*
 - c. *The project involves the conversion of existing space that results in excess square footage.*

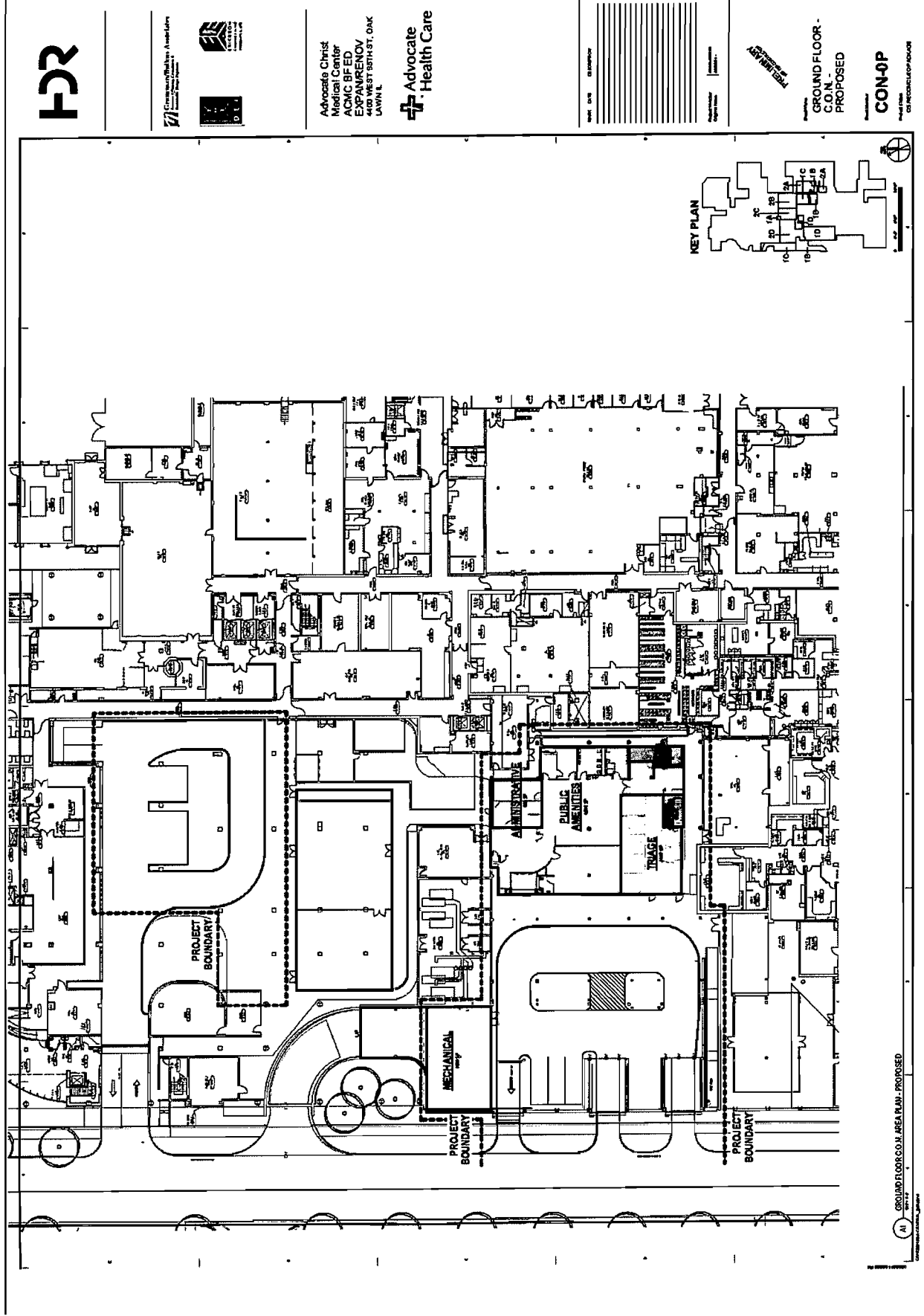
Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.

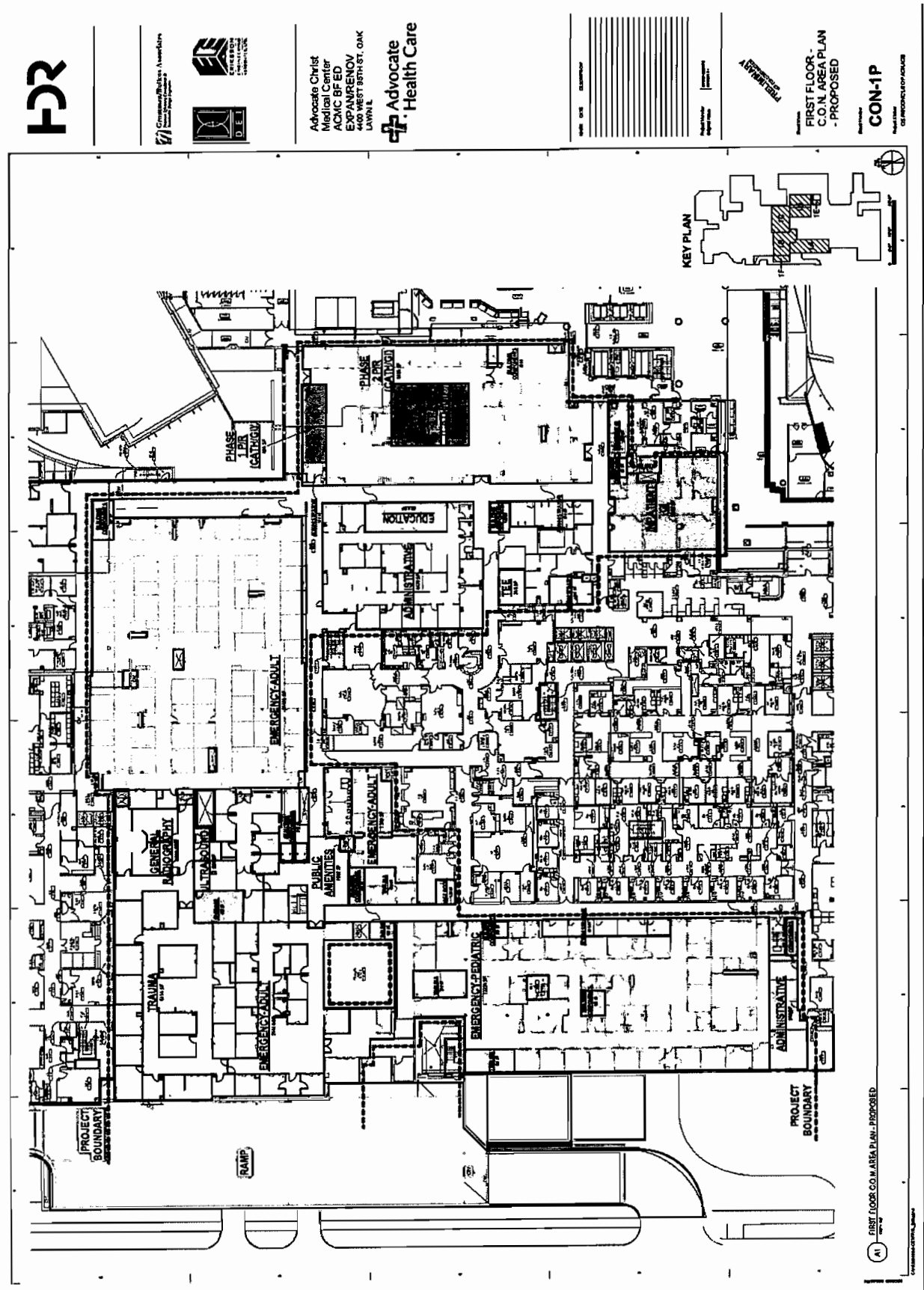
Department/Area	Project				
	Key Rooms	DGSF	DGSF / Key Room	State Agency Standard / Key Room	Met Standard ?
Triage	5	1,447	290	NA	NA
Trauma Center	12	7,342	612	NA	NA
Emergency Dept. Adult	52	22,737	438	900	YES
Emergency Dept. Pediatrics	18	13,324	740	900	YES
Subtotal Emergency Department	70	36,061	515	900	YES
GI/Endoscopy Lab Class B Procedure Room	3	2,672	891	1,100	YES
Phase I Recovery	10	1,751	175	180	YES
Phase II Recovery	21	8,184	390	400	YES
General Radiology	2	1,910	955	1,300	YES
Ultrasound Mobile	1	554	554	NA	NA
Cast Room	1	130	130	NA	NA
TEE	1	248	248	NA	NA

A diagram of the proposed project is included as Attachment 14, Exhibit 1.

The amount of physical space proposed for the Project is necessary and not excessive.

Attachment 14, Exhibit 1 includes drawings of the proposed Project. The unshaded area on the first floor is the existing cardiac catheterization lab with is not part of the Project





PROJECT SERVICES UTILIZATION:

This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B. **A narrative of the rationale that supports the projections must be provided.**

A table must be provided in the following format with Attachment 15.

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MET STANDARD?
YEAR 1					
YEAR 2					

APPEND DOCUMENTATION AS ATTACHMENT-15. IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The proposed Project includes 3 services that have established utilization standards or occupancy targets – emergency department, inpatient endoscopy lab, and general radiology. Need determination including projection methodologies are explained in detail in Attachment 34.

Emergency Department

Advocate Christ Medical Center (ACMC, Medical Center) used 4 methodologies to project future need for emergency treatment stations. See Attachment 15, Exhibit 1.

The first methodology had 3 components – a CAGR (compound annual growth rate) trend line, and factors to account for hours on bypass and the high percentage of patients who left without treatment. This methodology was calculated for 2 time periods – CY 2012 and RY 2014. CY 2013 was not used because utilization was negatively affected my major construction on the Medical Center site. Calculated visits divided by the State Guideline of 2,000 visits per treatment station ranged from 63 to 66 stations. As noted in the application, the Medical Center has been able to achieve 2,000 visits per station; however this visits per treatment station guideline, based on actual experience, is unrealistic because it results in very long wait times – as long as 10 hours.

However, if the more conservative guidelines of visits per station proposed by the American College of Emergency Physicians or the Emergency Department Benchmarking Alliance are applied to the projected balance from 89 to 97 treatment areas could be justified.

The second methodology was published by the American College of Emergency Physicians and is based on average census in the Medical Center on any hour of the day. Based on the 11 busiest hours, the Medical Center justified the need for from 65 to 78 stations, or an average of 72 stations. This methodology was also based on CY 2012 and RY 2014 data.

The third methodology was also published by the American College of Emergency Physicians and is based on the impact of key operational indicators. This methodology establishes the need for as many as from 89 to 96 emergency stations.

The fourth methodology is taken from information developed by the Emergency Department Benchmarking Alliance (EDBA). For hospitals with more than 80,000 visits (and ACMC projected from 125,000 to 130,000 visits), the EDBA's benchmark is 1,408 visits per treatment space. Based on this visits per space guideline, the Medical Center would also need from 89 to 96 stations.

The Medical Center is conservatively requesting 70 emergency treatment stations. At 70 stations, 125,075 projected visits equal 1,787 visits per room or 89.4 percent of the State Guideline. At 70 stations, 130,779 projected visits equal 1,857 visits per room or 92.9 percent of the State Guideline. Projected visits per room exceed the 2013 average utilization of emergency rooms in Illinois or in Health Planning Area A-04.

Inpatient Endoscopy

Need for endoscopy labs is based on current utilization.

General Radiology

Need is based on current utilization.

O. Criterion 1110.3030 - Clinical Service Areas Other than Categories of Service

1. Applicants proposing to establish, expand and/or modernize Clinical Service Areas Other than Categories of Service must submit the following information:
2. Indicate changes by Service: Indicate # of key room changes by action(s):

Service	# Existing Key Rooms	# Proposed Key Rooms
☒ Emergency Department	42	70
☒ Endoscopy/GI Lab	3	3
☒ General Radiology	16	18

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

PROJECT TYPE	REQUIRED REVIEW CRITERIA	
New Services or Facility or Equipment	(b) -	Need Determination - Establishment
Service Modernization	(c)(1) -	Deteriorated Facilities
		and/or
	(c)(2) -	Necessary Expansion
		PLUS
	(c)(3)(A) -	Utilization - Major Medical Equipment
		Or
	(c)(3)(B) -	Utilization - Service or Facility
APPEND DOCUMENTATION AS <u>ATTACHMENT-34</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.		

Level I Trauma/Resuscitation Center

Background

The Illinois Department of Public Health (IDPH) designates trauma centers as either Level I or Level II and has developed Emergency Medical Services (EMS) Systems across the state to coordinate the provision of emergency care in the event of disasters or mass casualties.

IDPH has designated Advocate Christ Medical Center (ACMC, Medical Center) as a Level I Trauma Center for adults and children. This designation means that the Medical Center has the staff and other resources to provide life-saving care to the most critically ill or injured patients; the Medical Center is also the Resource Hospital for the Level II Trauma Centers in the region such as Morris Hospital (Morris), Presence St. Joseph (Joliet), St. Mary's (Kankakee), Riverside (Kankakee), and Silver Cross (New Lenox), where patients may be stabilized and then transferred to the Medical Center for more advanced care..

Level I trauma means life-saving care to critically ill or injured patients; it means there is threat to life and limb and includes both blunt trauma (such as caused by motor vehicle accidents) as well as intentional trauma (such as caused by gun shots and stabbings). At ACMC, more than 20 percent of trauma cases are the result of intentional trauma.

Trauma is the most critical aspect of emergency care and represents a hospital-wide commitment of staff and other resources. For example, to be a Trauma Center there must be a trauma surgeon within the hospital at all times and many other specialists must be present or available within minutes such as representatives of many surgical specialties including cardiac, thoracic, vascular, orthopedic, spine, neuro, plastic, hand, ophthalmology, otolaryngology, obstetrics and gynecology, and urology. There must also be specially trained and credentialed nurses and other emergency support staff.

Other key departments in the hospital must be ready to respond to trauma care. An operating room must be reserved and immediately available 24/7 and a complete operating team in the hospital at all times; anesthesia service must be available at all hours. There must be physician coverage of the intensive care units. The American College of Critical Medicine designates the level of acuity that intensive care units can care for; ACMC has 4 Level I (the highest designation) intensive care units with 103 intensive care beds (79 adult beds and 24 pediatric) to accept trauma patients when they leave the Trauma I/Resuscitation Center or surgery. These intensive care units have all specially trained ancillary disciplines available such as respiratory, physical, occupational and speech therapy. A CT scanner tech must be available around the clock.

Many hospitals elect not to invest resources to Level I Trauma care and others have relinquished their designation because of the high cost of maintaining a Level I Trauma service.

IDPH has designated Advocate Christ Medical Center as the Resource Hospital for EMS System Region VII. The Medical Center is also the Regional Health Care Coordination Center for the region. There are only 11 hospitals with this designation in Illinois. ACMC's role is to coordinate communication, education, medical direction and response, surge, and resources for local, county, and statewide planned disaster exercises and for actual disasters. The Medical Center is also the Chair of the Region VII Health Care Emergency Preparedness Coalition, which includes multiple community partners (including 13 hospitals, police, fire, EMS, FBI, Red Cross and others). Further, ACMC is a National Disaster Management System (NDMS) hospital participant.

About Advocate Christ Medical Center's Level I Trauma/Resuscitation Service

Today, Advocate Christ Medical Center (ACMC, Medical Center) has 4 trauma rooms with 2 stations each that are used primarily for adults and 2 back-up pediatric exam rooms that can be used for pediatric trauma. The Project proposes to increase the number of trauma rooms from 8 stations to 12 private rooms. The high quality of the critical care provided in the Medical Center's Level I Trauma Center is substantiated by its 97 percent survival rate.

ACMC is the only Level I Trauma Center in EMS System Region VII. Consequently the geographic service area that it serves is as diverse as it is broad. Patients are from as far south as Kankakee, as far north as 58th Street in Chicago, as far west as Yorkville and Morris and much of Northwest Indiana.

Patient origin for the Level I Trauma Center is much broader than that for either inpatients or the emergency department mirroring the broad reach of the EMS System Region VII. See Attachment 12, Purpose.

The trauma patient population includes both children and adults, but the patient population for the large part is young men between the ages of 18 and 28, many of whom are uninsured. The Medical Center treats every patient who arrives at the Trauma Center as part of its mission.

The Medical Center's trauma service is also very involved in the treatment of other patients who require immediate attention when they arrive at the hospital (hence, the extended title Resuscitation Center). These include stroke and STEMI (a heart attack requiring aggressive treatment) patients and soon will include behavioral health patients. These patients are and will

be stabilized in the trauma/resuscitation center and moved to the Emergency Department or other clinical area depending on the outcome of immediate treatment.

The goal of the new behavior health program is to provide immediate intervention for behavior health patients and for patients with chronic health conditions (asthma, back pain, diabetes, kidney disease) which when linked to an underlying behavior health conditions (such as anxiety, dementia, depression) result in a high rate of emergency visits and inpatient admissions. By introducing effective screening tools and treatment methodologies, care for these patients will be meaningfully improved by initiating treatment earlier in the Trauma/Resuscitation Center (Trauma Center).

c) Service Modernization

The applicant shall document that the proposed project meets one of the following:

1) Deteriorated Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to historical utilization data, downtime or time spent out of service due to operational, upkeep and annual maintenance costs, licensure or fire code deficiency conditions the proposed project.

There are currently no code violations or life safety deficiencies in the Trauma I Center at Advocate Christ Medical Center. However, a study conducted in 2011 by a health facility planning consultant noted that the Trauma Center is deficient compared to contemporary standards. Further, the consultant noted that the Center falls well below contemporary standards for support and room size. In addition, the report identified other significant architectural issues including numerous mechanical chases and internal physical barriers, and a variation in grid structure. The proposed Project will resolve the suboptimal design of the current Trauma Center and its expanded capacity will meet current and expected future demand for trauma cases.

2) Necessary Expansion

The proposed project is necessary to provide for expansion of diagnostic, treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in scope of services offered, and licensure or fire code deficiency citations.

Among the goals of the Project is to increase the number of trauma/resuscitation rooms and to increase the area's square footage to better conform to contemporary industry standards.

The State Guidelines address neither utilization standard nor square footage per key room for trauma rooms.

The Medical Center determined future for trauma rooms based on CAGR (compound annual growth rate) trend lines and the likely impact of the new programs in the trauma-resuscitation area.

Access to the Medical Center's Level I Trauma/Resuscitation Center (Trauma Center) is on South Kilbourn Avenue. New construction of the Ambulatory Pavilion, located at the corner of South Kilbourn and West 95th Street resulted in congested access to the trauma center between CY 2012 and the early months of RY 2014. Although the Trauma Center is never on bypass to ambulance traffic, some trauma patients arrive by means other than ambulance and it appears that a small portion of this volume may have been deterred by the construction. Consequently, the Trauma Center reported a modest decline in utilization in CY 2012 and 2013, but regained its earlier volume and the trend lines from CY 2012 and RY 2014 show similar projected growth or 24.5 percent increase in visits. (RY 2014 includes the 12 months from September 2013 to August 2014.)

Increase in Adult and Pediatric Trauma Volume

Year	Trauma Visits
CY 2012	2,580
CY 2013	2,450
RY 2014	2,526
CY 2022	3,213
Percent Change	24.5

This increase does not include other uses of the trauma rooms for incoming patients with suspected stroke, STEMI (heart attack), and behavioral health patients. These patients receive immediate evaluation and treatment in the Trauma Center (hence the extended title of Trauma/Resuscitation Center) and then are moved to surgery, intensive care, or the Emergency Department or another appropriate department of the hospital. These patients are not counted in the current Trauma Center volume.

In 2013, the Medical Center received 1,176 stroke patients annually through the Trauma Center. (The Medical Center is an accredited Primary Stroke Center and has applied for accreditation as a Comprehensive Stroke Center.) The volume of stroke patients is expected to increase at a rate of 5 percent per year, so that by 2022, the Trauma Center will provide resuscitation services for an estimated 1,824 stroke patients. In addition, the Trauma Center received 115 STEMI patients who required immediate intervention. The Medical Center estimates that STEMI volume will also increase 5 percent per year, so that by 2022, STEMI patient volume is expected to increase to 179 patients. Further, the Trauma Center is initiating a new behavioral health component of the Trauma Center for patients with medical conditions and attendant behavioral health issues. The Medical Center has conservatively estimated behavioral health volume to 900 patients by 2022. Other resuscitation/immediate intervention programs may be added to the current complement in the future; however, based on the existing and imminent programs, the Trauma Center will account for approximately 2,900 high risk resuscitation patients in addition to the more traditional trauma patients.

Currently the 8 trauma stations are located in 1,432 DGSF or 179 DGSF per station. There is no State Guideline for square footage for trauma rooms; however the current trauma space is less than either the State's Guideline for emergency stations (900 DGSF per room) or the American College of Emergency Physicians Guideline (775 DGSF per room). It is not uncommon to have 10 or more doctors, nurses and other emergency technicians around a trauma bed. Clearly the size of the rooms is inadequate for not only movement of the staff around the bed, but also for the use of mobile equipment including large rapid infusion units. Further, for two patients in the same room separated only by a curtain (when one might be a cardiac arrest victim and the other awake and alert), the lack of privacy causes great anxiety for the alert patient who can hear everything said and done on the other side of the curtain. The proposed enlarged facilities will have 7,294 DGSF or 607 DGSF per room.

c) Utilization

A) Major Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B with 12 months after acquisition.

NA. There is no major medical equipment in the Project.

B) Service or Facility

Projects involving the modernization of a service or facility shall meet or exceed utilization standards for the services as specified in Appendix B. The number of key rooms being modernized shall not exceed the number justified by historical utilization rates for each of the latest two years can be justified per section c 2) Necessary Expansion.

Section 1110. Appendix B has no utilization standards for Level I Trauma/Resuscitation Services.

As noted throughout this application, Level I Trauma/Resuscitation Centers are very different than general emergency services. For example, as shown in Attachment 12, Purpose, the service area of the trauma services at the Medical Center is much broader than the service area for emergency services and reaches all or parts of 7 counties including Chicago's Southside, south suburban Cook County, Will County and Lake County, Indiana.

This broader service area reflects the unique requirements for a Level I Trauma Center that are not essential in a general emergency department; hence there are far fewer Level I Trauma Centers – Advocate Christ is the only one in its Health Planning Area. The Medical Center's Level I Trauma Service is also the only one in the Region VII of the Illinois EMS (Emergency Medical Services) System. A map of the broad reach of Region VII is also included in Attachment 12. During a disaster or major incident involving multiple injured victims, the Medical Center must have the ability to surge and accept many injured patients at one time. Most often, these patients are very acutely ill or critically injured and medical intervention cannot be delayed. These are random, unscheduled events.

Today, the Illinois Department of Public Health categorizes emergency services as standby, basic and comprehensive. IDPH also designates Level I and Level II trauma centers. The following are requirements for standby, basic and comprehensive emergency services and Level I Trauma Center.

A standby emergency service requires that one of the nurses on duty at the hospital be available for emergency services at all times. A licensed physician must be on call to the emergency department at all times. A standby emergency service must be able to provide immediate first aid and emergency care to people requiring such treatment on arrival at the hospital. A basic emergency service requires that at least one licensed physician be in the emergency department at all times. Physicians representing the specialties of medicine, surgery, pediatrics and maternity must be available within minutes. Basic ancillary services such as laboratory, x-ray,

and pharmacy must be staffed or on call at all times. A comprehensive emergency service requires at least one licensed physician be in the emergency department at all times. Physicians representing major specialties, as well as a limited number of subspecialties, must be on call and available within minutes. Laboratory and x-ray must be staffed round the clock and pharmacy must be staffed or on call.

In contrast, a Level I Trauma Center must admit at least 240 patients a year with an Injury Severity Index of more than 15; a general surgeon or PGY (post graduate year) 4 or 5 resident must be in-house 24/7 to participate in major resuscitations, therapeutic decisions or operations. Emergency physicians must be present in the department at all times and a neurosurgeon must be designated as the liaison. Plastic surgery, hand surgery and spinal injury care capabilities must be present. A Level I Trauma Center must have an operating room that is immediately available and a complete operating team in the hospital at all times, with individuals who are dedicated only to the operating room. A trauma surgeon must be in-house around the clock. Anesthesia service must also be available 24/7. In addition, a CT tech and in-house physician coverage of the intensive care units must be available around the clock. Finally, there must be a continuous rotation of trauma surgery for senior residents that are part of an Accreditation Council for Graduate Medical Education. A trauma center must be accredited in any of the following disciplines: general surgery, orthopedic surgery, or neurosurgery, or it must support an acute care surgery fellowship consistent with the educational requirements of the American Association for the Surgery of Trauma. Because of the high cost of maintaining a trauma center, most hospitals elect not to seek Level I trauma designation and others have chosen to relinquish their designation.

Based on these definitions, it is evident that there is a vast difference between standby, basic and comprehensive emergency departments and Level I trauma centers. Although these designations differentiate between levels of care, physician staffing and availability of support services as well as prescribe other attributes, the State Agency has only one Utilization Guideline to determine the need for treatment rooms or stations regardless of service designation or the complexity of care provided. The single State Guideline is 2,000 visits per year per treatment station. In 2013, the State average emergency room utilization for all levels of emergency rooms was only 1,560 visits per year and the Health Planning Area A-04 the rate was only 1,733 visits per year. It is unrealistic to apply the 2,000 visits per room guideline to trauma centers to a Level I Trauma Center.

The applicants have justified the proposed increase from 8 adult and 2 back-up pediatric trauma stations to 12 universal stations based on current trauma experience, CAGR projected trauma

volume, as well as future volume of trauma rooms as resuscitation rooms for high risk stroke, STEMI (heart attack), and behavioral health patients. The CAGR trend line is provided on Attachment 34, Exhibit 1 and the resuscitation volume is summarized below. Based on these conservative projections, trauma and resuscitation volume is expected to reach at least 6,113 visits or an average of 17 patients per day by 2022.

Projected Level I Trauma/Resuscitation Center Volume, 2022

Services	Visits
Level I Trauma	3,213
Resuscitation Services (stroke, STEMI, behavioral health)	2,900
Total	6,113

Advocate Christ Medical Center Trauma
Projections, 2003 - 2022

TOTAL - Adult & Pediatrics		Actual Volume									
Year		2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
	Trauma	-	-	-	2,262	2,636	2,564	2,544	2,509	1,470	2,580

TOTAL - Adult & Pediatrics		Projected Volume									
Year		2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
	Trauma	2,637	2,696	2,756	2,817	2,879	2,943	3,008	3,075	3,143	3,213

Source: IDPH AHQ; Medical Center Financial Records

Clinical Service Areas

Emergency Department

Background

Advocate Christ Medical Center (ACMC, Medical Center) is proposing to modernize and expand its Emergency Department capacity from 42 to 70 emergency/non-trauma stations. Several factors influenced the decision to move forward with this Project, not the least being the high visit volume, overcrowding and excessively long waits in the existing undersized department. The plan being proposed was also shaped by important changes in the delivery of emergency services nationally. These changes were reported in "The Evolving Role of Emergency Departments in the United States," a research report published by the Rand Corporation in 2013.

Hospital emergency departments are a relatively recent phenomena emerging in the years following World War II. The physician staffing of emergency departments changed dramatically in the intervening years from part-time coverage by community physicians or moonlighters to full-time, round-the-clock coverage by residency trained, board certified emergency physicians. The highly specialized knowledge and skills these emergency physicians possess allowed hospital emergency departments to dramatically expand their capability to diagnose and manage a wide range of clinical conditions. These enhanced capabilities to manage complex and time-critical problems have also given these physicians more options to diagnose and manage these cases without resorting to hospital admissions.

While the primary role of the emergency services is to provide care to the sick and injured, Advocate Christ Medical Center's Emergency Department, as well as other leaders around the country, serve an increasingly wide range of societal roles. To some degree these roles relate to the severe shortage of primary care physicians across the United States. In a news release dated October 31, 2014, Daryl G. Kirch, M.D, President and CEO of the Association of American Medical Colleges, is quoted as saying that the U.S. is facing a worsening shortage of primary and specialty physicians over the next two decades.¹ Not only will primary care physicians be in short supply for the long-term, there is a growing differentiation of generalist practice into two groups: primary care physicians who largely restrict their practices to outpatient settings and a second set of "hospitalist" physicians who focus on treating hospital inpatients. With hospitalists focusing on high acuity inpatient care and emergency physicians specializing in high acuity and

¹ <https://www.aamc.org/newsroom/newsreleases/411636/10282014.html>

undifferentiated outpatient care, office-based primary care physicians have less need to accommodate unscheduled visits by acutely ill patients. The arrival of an acutely ill patient can seriously disrupt a physician's tightly scheduled day. In such situations, it is much easier for him to direct a patient to the nearby emergency department.

Hence, the first expanded role of emergency departments relates to these evolving primary care practice dynamics. Primary care physicians are increasingly depending on emergency departments to perform accelerated diagnostic work-ups for patients with potentially serious problems. There are obvious advantages to this strategy; emergency departments have access to advanced diagnostic technology that is rarely available in physician offices and the emergency staff has ready access to subspecialist consultants and interventionalists, if needed.

The second expanded role relates to managing an intense period of treatment that avoids the need for a far more costly hospital stay. The recent adoption of rapid "rule out" protocols has been credited with a declining number of admissions or readmissions. Since an average hospital stay costs 10 times as much as an emergency department visit, the importance of this new role is not inconsequential. Emergency departments are increasingly being seen as the "final line of defense" to prevent costly admissions and readmissions.

And finally, hospital-based emergency departments provide care to the insured, the low income and uninsured including undocumented immigrants who cannot obtain timely access to care elsewhere. This is in keeping with the congressionally mandated obligation to serve as "the safety net of the safety net."

About Advocate Christ Medical Center's Emergency Department

Two hospitals are located on the ACMC campus – Advocate Christ Medical Center (an adult tertiary/quaternary full service hospital) and Advocate Children's Hospital – Oak Lawn (a specialty pediatric hospital). The combined emergency department for both hospitals is located in the Medical Center.

The Medical Center's Emergency Department has been designated as a comprehensive emergency service-this designation is the highest category recognized by the Illinois Department of Public Health. The Department has also been designated by the Illinois Department of Emergency Services as an Emergency Department Approved for Children. Pediatric patients are treated in a separate area within the department with a different clinical team than the adult treatment area.

By mid-year 2014, Advocate Christ Medical Center's utilization substantially recovered from the temporary reduction caused by major construction on the site near the entrance to the Emergency Department. In RY 2014 (September 2013 to August 2014), APMC's Emergency Department treated 95,556 patients, approximately one-third of which were children. This volume translates into 261.8 patients per day or 10.9 patients arriving per hour (one every 5.5 minutes). Averages, however, are not a true measure of the Departments activity levels since the range of visits per hour range from 3.3 to 18.7. Nationally, and at the Medical Center, visits per hour are highest from mid morning until early evening. During these peak hours of utilization, it is not uncommon to have 50 patients in the waiting room at the Medical Center because all 42 emergency stations and 18 curtained cubicles are occupied.

Utilization of APMC's Emergency Department
Per Day, Per Hour, and Peak Utilization RY 2014
(September 2013 – August 2014)

Day of Week	Pediatric	Adult	Total	Average Per Day	Average Per Hour	Range of Visits Per Hour
Sunday	3,969	9,297	15,266	255.1	10.6	4.3 – 16.3
Monday	4,203	9,660	13,863	266.5	11.1	4.7 – 16.5
Tuesday	4,375	10,375	14,750	283.7	11.8	4.0 – 18.7
Wednesday	3,986	9,532	13,518	260.0	10.8	3.5 – 16.5
Thursday	4,028	9,512	13,540	260.4	10.9	3.7 – 17.6
Friday	3,862	9,465	13,327	256.3	10.7	3.3 – 17.2
Saturday	3,766	9,526	13,292	255.6	10.7	3.4 – 16.4
	28,189	67,367	95,556	261.8	10.9	3.3 – 18.7
Source: Medical Center Records						

The following chart from Medicare.gov/hospital/compare documents the long wait times at the Medical Center and compares them to Illinois and national averages.

Comparison of Wait Times, APMC, Illinois and National

	Advocate Christ Medical Center	Illinois Average	National Average
Average time patients spent in the emergency department, before they were admitted to the hospital as an inpatient <i>(a lower number of minutes is better)</i>	360 Minutes	260 Minutes	274 Minutes
Average time patients spent in the emergency department, after the doctor decided to admit them as an inpatient before leaving the emergency department for their inpatient room <i>(a lower number of minutes is better)</i>	210 Minutes	89 Minutes	98 Minutes
Average time patients spent in the emergency department before being sent home <i>(a lower number of minutes is better)</i>	195 Minutes	138 Minutes	134 Minutes
Average time patients spent in the emergency department before they were seen by a healthcare professional <i>(a lower number of minutes is better)</i>	81 Minutes	28 Minutes	26 Minutes
Average time patients who came to the emergency department with broken bones had to wait before receiving pain medication	19 Minutes	52 Minutes	57 Minutes
Percentage of patients who left the emergency department before being seen <i>(lower percentages are better)</i>	3%	3%	2%
Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrive <i>(Higher percentages are better)</i>	Not Available	64%	57%

The Emergency Department supports a major emergency medicine teaching residency that includes 45 residents, (15 from each year of the 3-year program). Although the Medical Center's primary affiliation is with the University of Illinois Chicago Medical School, (UIC), there are also other academic affiliations. The program includes a Simulation Learning Center and is known for its exceptional training in ultrasound applications at the bedside. Further, the medical center trains more than 2,500 emergency medical technicians, paramedics, and other providers of emergency care annually through the Emergency Medical Services (EMS) Academy.

The Emergency Department is staffed by 59 board certified emergency physicians, most of whom have faculty appointments at the UIC, specially trained nurses and other emergency care professionals. Additionally, physicians in multiple specialties including those available to the Level I Trauma Center are available to provide emergency care.

The Medical Center's location near the intersection of two major highways makes it readily accessible by public transportation. The campus also has free garage parking, and surface parking including lots directly across the street from the Emergency Department drop-off/triage area.

Advocate Christ Medical Center's Emergency Department is an essential community resource and safety net.

c) Service Modernization

The applicant shall document that the proposed project meets one of the following:

1) Deteriorated Equipment or Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, licensure or fire code deficiency conditions involving the proposed project.

There are currently no code or life safety deficiencies in the Emergency Department at Advocate Christ Medical Center. However, a study conducted in 2011 by a health facility planning consultant noted that the Emergency Department was deficient compared to contemporary standards and was running well over expected capacity levels. The consultant also noted that the department falls well below contemporary standards for department support and room size. Currently the 42 emergency stations are located in 21,081 DGSF, or 502 DGSF per station,

substantially below the State Guideline of 900 DGSF per station. In addition, the consultant's report identified that the area has significant architectural and operational issues. Among these issues are limited capacities for patient arrival and drop off, numerous mechanical chases and internal physical barriers, and variations in the grid structure. The proposed Project design will resolve the suboptimal design of the current unit and the expanded capacity will meet current and expected future demand for emergency cases.

2) Necessary Expansion

The proposed project is necessary to provide for expansion for diagnostic, treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in scope of services offered, and licensure or fire code deficiency citations.

One of the goals of the Project is to increase the capacity of the Emergency Department from 42 to 70 stations and to increase the square footage to better conform to contemporary industry standards. Historical utilization from CY 2011 through RY 2014 of the department's 42 stations substantially exceeded the State Guideline of 2,000 visits per station as well as the State average of 1,560 visits and Health Planning Area A-04 average of 1,733 visits per station.

Utilization of the Adult and Pediatric Emergency Department at ACMC, CY 2012 – RY 2014

Year	Rooms	Visits	Visits per Room
CY 2012 ¹	42	93,119	2,217
CY 2013 ¹	42	91,901	2,188
RY 2014	42	95,556	2,275

Source: Medical Center Records

¹ Major construction occurring on the campus negatively affected Emergency Department utilization.

Because of the very long wait times and the extremely high census, the Medical Center developed 18 curtained cubicles in the Emergency Department. These cubicles, only 2 ft. x 7 ft. in size, lack privacy and call lights, although portable telemetry and medical gasses are available (see Attachment 34, Exhibit 2). These curtained cubicles are routinely used so staff can better monitor patients who are too sick or injured to remain in the waiting room until an emergency station becomes available. Very frequently the 42 emergency stations as well as the

18 cubicles are occupied. Hence, although the Emergency Department has only 42 recognized emergency stations the functional capacity of the department is 60 stations. Based on this functional capacity, the Medical Center is requesting a 16.7 percent increase in Emergency Department stations or from 60 to 70 stations. A diagram of the current unit showing the location of the curtained cubicles is included as Attachment 34, Exhibit 3.

Emergency Department Station Need Methodologies

Need Based on Current Utilization and State Guidelines

Based on volume during the last 3 years and the State Guideline the Medical Center could justify 46 to 48 emergency stations.

CY 2012

$$93,911 \text{ visits} \div 2,000 \text{ visits per station} = 47 \text{ stations}$$

CY 2013

$$91,901 \text{ visits} \div 2,000 \text{ visits per station} = 46 \text{ stations}$$

RY 2014

$$95,556 \text{ visits} \div 2,000 \text{ visits per station} = 48 \text{ stations}$$

According to the State Guideline, the Medical Center requires only from 4 or 6 more stations than it currently has and from 12 to 14 fewer than are available when the cubicles are included. This calculated need based on the State Guideline is not reasonable based on the Medical Center's experience treating high acuity patients in a very crowded, stressed environment. This number of stations would continue to require extraordinary long wait times, increasing number of bypass hours, and a high number of patients leaving without treatment.

Need Based on Future Utilization

Over the recent past, swings Emergency Department utilization reflect the disruption caused by major construction on the Medical Center campus. The construction of the Medical Center's new Ambulatory Pavilion impeded traffic to the Emergency Department entrance during 2012, 2013 and early 2014; The Ambulatory Pavilion opened in March of 2014 thereby clearing construction impediments and providing easier access and additional free parking for emergency patients. Because of this extraordinary circumstance, the Medical Center developed 3 CAGR (compound annual growth rate) trend lines to determine a range of future Emergency Department volume.

The first trend line (Attachment 34, Exhibit 4) is based on historical data from 2003 to 2012 and projections from 2013 to 2022. This trend line was prepared to determine the impact the construction near the Emergency Center entrance and resulted in 2022 projected Emergency Department visits of 116,384. The second trend line (Attachment 34, Exhibit 5) is based on historical data from 2005 to 2022 and projections from 2014 to 2022. This trend line clearly

shows the impact of construction on emergency volume. Not only are the 2013 visits lower than the 2012 visits, the projections are also considerably lower at 107,552 visits in 2022. The third CAGR trend line is based on RY 2014 (September 2013 through August 2014) (Attachment 34, Exhibit 6). This trend line essentially eliminates the negative impact of the construction that affected the 2012 and 2013 trend lines and is more consistent with previous years. The following table summarizes these 3 trend lines.

Summary of CAGR Trend Lines, 2012, 2013 and RY 2013

Year	Total Visits	CAGR to 2022	Percent Change
2012	93,119	116,384	25.0
2013	91,901	107,552	17.0
RY 2014	95,556	119,856	25.4

The summary clearly demonstrates the disruption of emergency volume and its recovery in RY 2014.

These volumes, however, do not account for two other significant factors that will influence future utilization of the Emergency Department – bypass and patients left without treatment.

Bypass

When the Medical Center is at peak utilization and cannot accept any additional emergency patients, it must go on bypass (the Medical Center does not go on bypass for trauma patients). When on bypass, ambulances must take patients to other facilities. Bypass delays treatment and potentially compromises outcomes. Between CY 2012 and RY 2014, hours on bypass increased substantially. Based on experience, the Medical Center has conservatively determined that for each hour 6.5 ambulance arrivals and an equivalent number of patients that would have otherwise been treated at the Medical Center are diverted to another facility. The following is a summary of hours on bypass and the number of redirected patients.

Year	Hours on Bypass	Number of Diverted Patients
CY 2012	647	4,206
CY 2013	1,030	6,695
RY 2014	1,358	8,827

With the proposed expansion of the Emergency Department, these patients will infrequently be diverted and will be seen at the Medical Center.

Left without Treatment (LWOT)

Because of the extremely long wait times at the Medical Center, the proportion of patients who leave without treatment is 1.5 times the national average. For whatever reasons, there will always be some patients who choose to leave an emergency room without treatment. However, the Medical Center estimates that the current rate will be reduced to the national average, and perhaps lower. Based on recent experience, the Medical Center's number of patients LWOT will be reduced to 1,996 per year.

Future volume based on either a 2012 base year or a RY 2014 based year ranges from 125,075 to 130,770 Emergency Department visits to the Medical Center. At the State Guideline of 2,000 visits per year, these volumes would support from 63 to 66 emergency stations.

CY 2012 Base Year

CAGR trend line + bypass+ reduced LWOT = total 2022 visits

$$116,384 + 6,695 + 1,996 = 125,075 \text{ visits}$$

$$125,075 \text{ visits} \div 2,000 \text{ visits per year} = 63 \text{ stations}$$

RY 2014 Base Year

CAGR trend line + bypass + reduced LWOT = total 2022 visits

$$119,956 + 8,827 + 1,996 = 130,779 \text{ visits}$$

$$130,779 \text{ visits} \div 2,000 \text{ visits per year} = 66 \text{ stations}$$

As shown in the following alternative methodologies developed by the American College of Emergency Physicians, the 2013 average utilization of all emergency departments (standby, basic and comprehensive) in Illinois and in Planning Area A-04 (1,560 and 1,733 respectively), and the high acuity (and consequently longer times in the Emergency Department) of the patients, and the new, innovative, cost saving roles that are being introduced into the Medical Center's Emergency Department, the need determination using the State Guideline for stations is understated.

American College of Emergency Physician Methodologies

The American College of Emergency Physicians (ACEP) published two methodologies for determining the number of emergency stations needed by a provider. The first is based on hourly census in an emergency department and the second is based on a range of operational indicators. Based on these methodologies, the appropriate number of visits per room at Advocate Christ Medical Center could range from 1,250 to 1,875 visits per room, compared to the State Guideline of 2,000 visits per room.

ACEP Methodology #1 – Emergency Department Census

The Medical Center has reported 50 stations each year in the Annual Hospital Questionnaire; of these, 8 are for trauma patients and 42 are emergency stations. In addition to the emergency stations, the Medical Center developed 18 hallway curtained cubicles with portable medical gasses and telemetry, but no call lights or privacy. Any other available space is commandeered to care for the high volume of patients. The Medical Center is conservatively requesting 70 adult and pediatric emergency exam and treatment stations, or an increase of 26 stations.

In order to use this emergency department census-based methodology, the Medical Center first determined the average hourly census for every day of the year by day of the week. The following table shows that during the 11 busiest hours of the day, the patient census exceeded available beds by from 11 to 24 patients. It was possible for the Medical Center to accommodate this high number of patients because of the 18 temporary hallway curtained cubicles and other temporary spaces.

Comparison of Peak Hour Emergency Department Census
and Available Treatment Stations
RY 2014 (September 2013 – August 2014)

Hour	Average Peak Hour Census ¹	Available Treatment Stations	Difference- Peak Census and Available Treatment Stations
10:00 AM	56.3	42	14.3
11:00 AM	63.7	42	21.7
12:00 PM	56.4	42	14.4
1:00 PM	62.0	42	20.0
2:00 PM	65.3	42	23.3
3:00 PM	65.8	42	23.8
4:00 PM	65.1	42	23.1
5:00 PM	64.3	42	22.3
6:00 PM	62.2	42	20.2
7:00 PM	58.7	42	16.7
8:00 PM	52.8	42	10.8

¹ Assumes emergency visits are 97.4 percent of combined trauma and emergency visits.

Source: Medical Center Records

Based on this hourly census, the Medical Center calculated the number of emergency stations needed. The ACEP recommends a target utilization of from 80 to 90 percent. On the following table, the Medical Center calculated three utilization levels – 80, 85, and 90 percent. Based on the 85 percent utilization level by hour of the day in RY 2014, the Medical Center could support from 65 to 78 emergency exam and treatment station or an average of 73 stations. The Medical Center is conservatively requesting 70 adult and pediatric emergency stations.

Emergency Stations Needed Based on 80 Percent, 85 Percent, and 90 Percent
Peak Utilization RY 2014 (September 2013 – August 2014)

Hour	Average Total Census	Stations Need At		
		80 Percent	85 Percent	90 Percent
10:00 AM	56.3	71	67	63
11:00 AM	63.7	80	75	71
12:00 PM	56.4	71	67	63
1:00 PM	62.0	78	73	69
2:00 PM	65.3	82	77	73
3:00 PM	65.8	83	78	74
4:00 PM	65.1	82	77	73
5:00 PM	64.3	81	76	72
6:00 PM	62.2	78	74	70
7:00 PM	58.7	74	69	66
8:00 PM	52.8	73	65	68

Source: Medical Center Records

ACEP Methodology #2 – Operational Indicators

The second ACEP methodology provides indicators identified as "low range" and "high range." If a hospital meets or exceeds the majority of the 12 indicators, it qualifies to use the "high range" to determine the number of treatment stations and square footage recommended in the ACEP Guidelines. The Medical Center carefully completed the profile and meets the majority of the indicators. Attachment 34, Exhibit 7 is a summary of the operational indicators worksheet used in the ACEP methodology. Advocate Christ Medical Center meets the majority of these indicators. The following is a brief summary of ACMC's compliance with the high range indicators.

Length of Stay

If the average total length of stay for all emergency department patients will be more than 3.5 hours, a hospital qualifies as "high range." The average length of stay at the Medical Center was 4.5 hours in 2013.

Location of Holding or Observation Beds

The Medical Center will have admit holding on the unit and not in a special area. Hence the program qualifies as "high range."

Time to Admit

If emergency department patients who are admitted to the hospital remain in the department more than 90 minutes after disposition, the service qualifies for "high range" designation. Admitted patients wait on the unit a minimum of 3 hours and on occasion as long as 10 hours. Therefore ACMC qualifies this criterion as "high range."

Turn Around Time for Diagnostic Tests

If turn around times for imaging and laboratory results will be more than 60 minutes, then the program qualifies as a "high range" provider. Currently lab exceeds the 60 minutes; however imaging time is shorter. To be fair, the Emergency Department was given only a "partial yes" on this indicator.

Percentage of Patients Admitted

If more than 23 percent of emergency patients are admitted to the hospital, then the service meets the criterion for "high range." At ACMC, 24 percent of the emergency patients are admitted.

Percentage of Non Urgent vs. Urgent Patient Presentations

If urgent patients outnumber non-urgent patients by more than 10 percent, the department is considered having a high acuity patient population with longer lengths of stay. At the Medical Center, 70 percent of the patients are urgent and 30 percent are non urgent; therefore the emergency service qualifies as a "high range" candidate.

Age of Patients

If more than 25 percent of patients will be older than 65 years, the hospital qualifies as a "high range" provider. Currently, the Medical Center's proportion of senior patients is 18 percent. With the aging of the population and the introduction of a special geriatric program in the Emergency Department, the Medical Center expects this proportion to increase. However, to be conservative a "no" response has been given on this criteria.

Need for Administrative or Teaching Space

The Medical Center has a large emergency medical residency program as well as a large program in conjunction with the Emergency Medical Service (EMS) Academy. Nurses and other health professionals also train in the emergency department. For these reasons, the Medical Center was given a "yes" on this criterion.

Imaging Services included within the Emergency Department

The expanded and modernized emergency department will have two general radiography units and mobile ultrasound on the unit. Hence imaging services will be provided in the department and the Medical Center qualifies as a "high range" provider.

Specialty Components – Pediatric Area

ACMC will have a large area for pediatric patients; approximately 30 percent of the Medical Center's emergency patients are pediatric. For these reasons, the Medical Center qualifies as a "high range" provider. The proposed emergency department will have 18 pediatric exam rooms and the capability to care for pediatric trauma patients.

Specialty Components – Psychiatric Patient Volume

If the provider's volume includes a high proportion of psychiatric (behavioral health) patients, the provider is classified in the "high range" category. ACMC's case mix includes a high volume of behavioral health patients; in fact, 5 rooms in the modernized and expanded Emergency Department will be designated and equipped for behavioral health patients. Demand for behavioral health services in the Emergency Department is expected to increase with the closing of chronic mental health services across the State. For these reasons, the Medical Center qualifies as a "high range" provider.

Flight Services or Trauma Services

Flight services and Level I trauma services are provided at the Medical Center. Hence, ACMC qualifies as a "high range" provider.

With 10.5 out of a possible 12 "high range" responses, the Medical Center has qualified to use the "high range" criteria.

Figure 6.5 on Attachment 34, Exhibit 8 shows the American College of Emergency Physicians' recommendation for exam stations/rooms based on the outcome of the operational indicators assessment and projected volume. According to their recommendation, Advocate Christ

Medical Center should plan for from 82 to 89 exam stations/rooms even at a future level of 116,000 visits and as many as 89 to 96 with the 126,000 to 130,000 visits projected in the CAGR projection methodology. The Medical Center is conservatively requesting 70 emergency exam stations/rooms. The Medical center is also proposing to have 12 Level I Trauma/Resuscitation rooms.

Emergency Department Benchmarking Alliance

The Emergency Department Benchmarking Alliance (EDBA) is a not-for profit organization which exists solely to support people who manage emergency departments across the county. Among the ways they do this is to maintain an independent unbiased database of demographic and performance metrics. This data base contains some of the cleanest information in the industry; over 800 hospitals are represented in the data base.

For hospitals with over 80,000 annual visits, EDBA's benchmark is 1,408 visits per space. Based on this benchmark, the Medical Center can justify from 89 to 96 stations based on from 125,075 to 130,779 annual visits. Even at 116,000 projected visits, the Medical Center can justify 83 stations.

c) Utilization

A) Major Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

NA. There is no major medical equipment in this Project.

B) Service or Facility

Projects involving modernization of a service or facility shall meet or exceed utilization standards for the services as specified in Appendix B. The number of key rooms being modernized shall not exceed the number justified by historical utilization rates for each of the latest 2 years, unless additional key rooms can be justified per section c) 2) Necessary Expansion,

- C) *If no utilization standards exist, the applicant must document in detail its anticipated utilization in terms of incidence of disease or conditions or population use rates.*

Advocate Christ Medical Center has justified the need to increase the number of emergency department exam rooms in subsection 2) Necessary Expansion.

There is a State Guideline for utilization of emergency services. It is 2,000 visits per treatment station. The applicants have described the limitations of this Guideline and have justified the proposed expansion of the Medical Center's Emergency Department from 42 exam/treatment stations and 18 curtained cubicles to 70 exam/treatment rooms using methodologies published by the American College of Emergency Physicians and the Emergency Department Benchmarking Alliance.

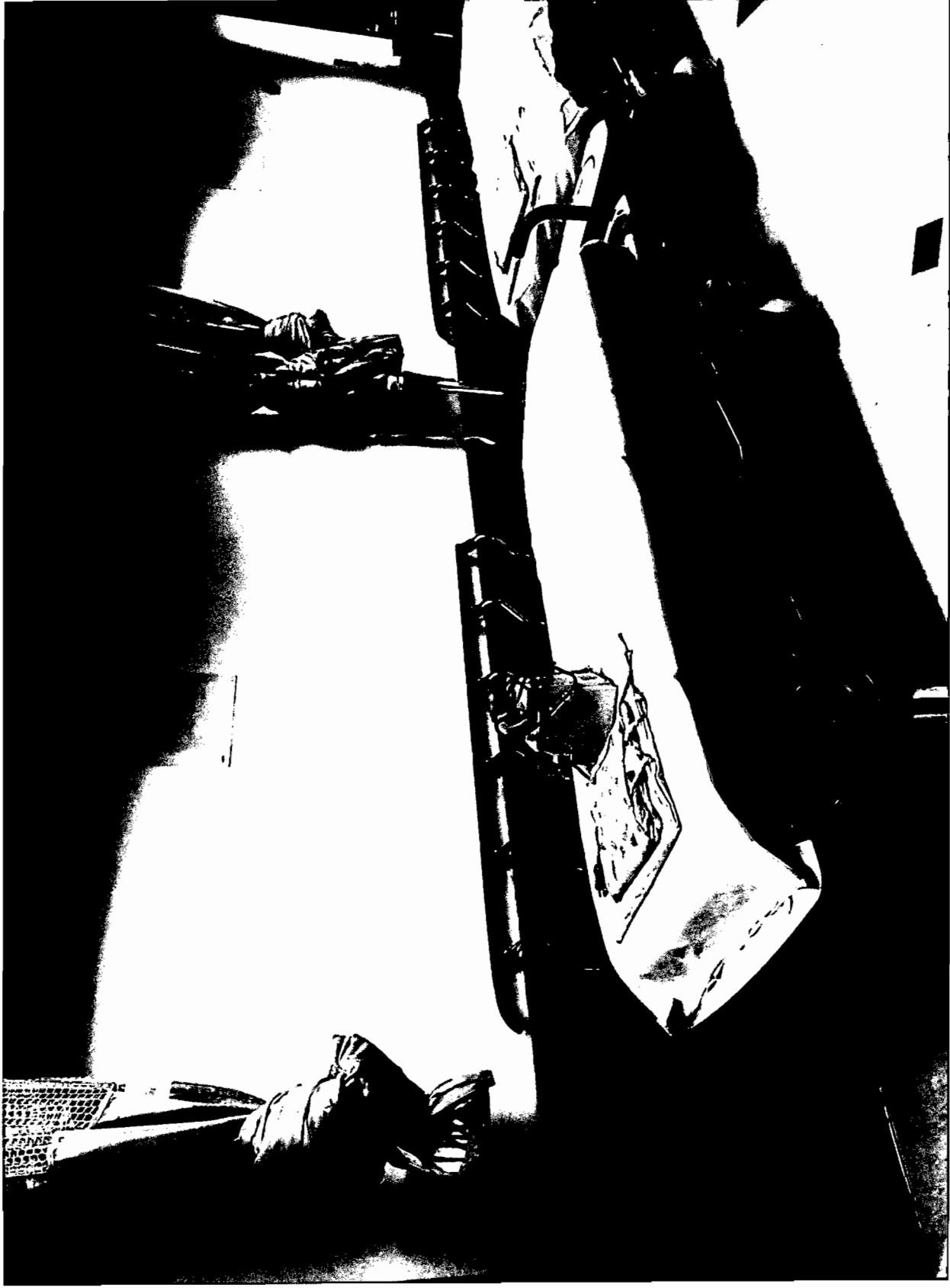
Based on CAGR trend lines of adult and pediatric emergency patients, the levels of acuity, the average time spent in a treatment station, and the peaks in utilization, the Medical Center determined that the appropriate mix of emergency stations would be 18 pediatric stations and 52 adult stations. Of the adult stations, 5 will be specially designed and equipped for behavior health patients and the department will have special accommodations for geriatric patients – one of the first hospitals in Illinois to do so. The design of the department provides flexibility between the adult and the pediatric sections of the Emergency Department to adjust to unexpected peaks in either adult or pediatric volume. The pediatric area is capable of being isolated in the event of a pandemic.

Based on 4 methodologies the Medical Center justified from 66 to 96 emergency stations and is conservatively requesting 70. Of these, 18 will be pediatric and 52 will be adult; however, the unit has been designed to allow for flexibility between the pediatric and adult stations, as need arises. There will be no curtained cubicles.

Methodology	Number of Stations Justified
CAGR extended with bypass and left without being treated patients	66
American College of Emergency Physicians – Methodology #1 – Census Based	73
American College of Emergency Physicians – Methodology #2 – Operational Indicators	89 – 96
Emergency Department Benchmarking Alliance	89 – 96

The Medical Center's need determination for emergency exam and treatment stations is conservative based on recognized methodologies developed by the American College of Emergency Physicians and the Emergency Department Benchmarking Alliance. These need projections are conservative because they do account for emerging changes in the delivery of emergency care which has been factored into the Medical Center's need assessment. Examples of these changes include:

- In CY 2013, the Medical Center was on bypass 1,030 hours; in RY 2014, the number of hours increased to 1,358. With more emergency and trauma stations, the number of bypass hours will be reduced and patients that currently are diverted to other facilities will be treated at ACMC. Reduced bypass time is expected to increase Emergency Department volume by as many as 8,827 visits per year. When emergency patients are diverted, time to treatment is delayed and outcomes are potentially compromised.
- When the proposed number of emergency stations becomes available, waiting times in the ED are expected to decline; concurrently the number of patients who leave without treatment (LWOT) is expected to decline from the current 3 percent to 2 percent or less or result in 1,996 or more patients per year. Timely treatment benefits patients because they are treated earlier in the disease process.
- Under the Affordable Care Act, many of the currently uninsured population are expected to use emergency room services, especially if they cannot readily access a primary care physician in a timely way. The shortage of primary care physicians is expected to continue for at least 2 decades.
- Primary care physicians who remain in office practice will increasingly send patients with acute conditions to an emergency department where there is ready access to diagnostic modalities and specialists and to avoid cumbersome preapproval admission insurance processes.
- Aging of the population will result in more people living longer and developing chronic and often complex diseases with acute episodes requiring immediate care. They will elect to use the emergency department or their physician will send them there for immediate evaluation, potentially reducing the number of costly hospital admissions and readmissions.
- Advocate Christ Medical Center will continue to be a safety net for those who remain without insurance.



80V ACMCED CON

11/4/2014 12:32 PM

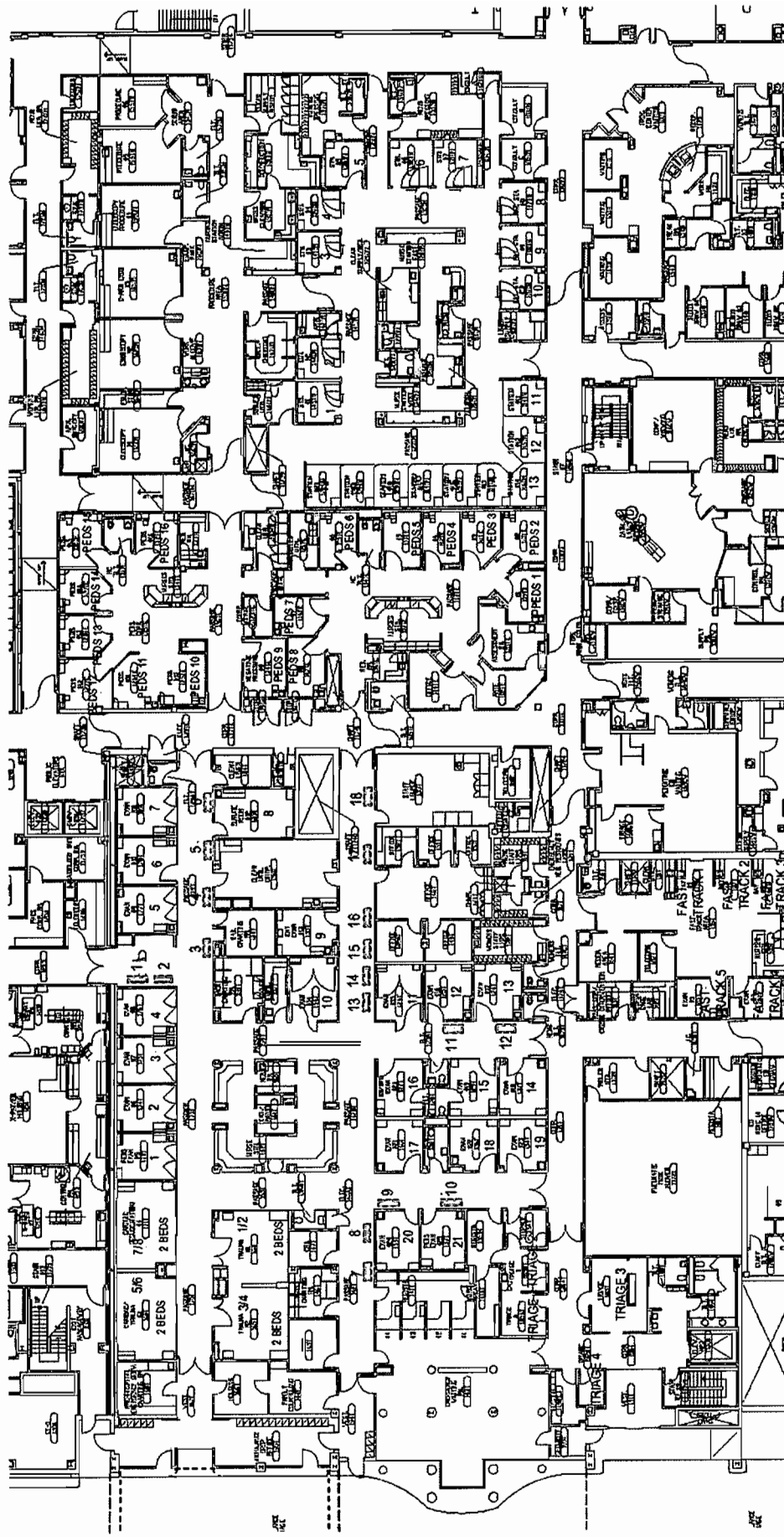
145

Attachment 34

Clinical Services Areas

Emergency Department

Exhibit 2



18 CURTAINED CUBICLES

8 BEDS FOR TRAUMA
 21 ADULTS EMERGENCY
 16 PED EMERGENCY
 5 FAST TRACK
 TOTAL 50

SEPTEMBER 22, 2014

Current Emergency Design

80V ACMC ED CON	146	Attachment 34
11/4/2014 12:32 PM		Clinical Services Areas
		Emergency Department
		Exhibit 3

Advocate Christ Medical Center Emergency Department
Projections, 2003 - 2022

TOTAL - Adult & Pediatrics

Year	Actual Volume					
	2003	2004	2007	2008	2009	2010

Non-Trauma	76,185	75,222	78,371	78,390	83,584	83,077
------------	--------	--------	--------	--------	--------	--------

TOTAL - Adult & Pediatrics

Year	Projected Volume					
	2013	2014	2017	2018	2019	2020

Non-Trauma	95,219	97,366	104,104	106,451	108,852	111,307
------------	--------	--------	---------	---------	---------	---------

Source: IDPH AHQ; Medical Center Financial Records

Advocate Christ Medical Center Emergency Department
Projections, 2005 - 2022

TOTAL - Adult & Pediatrics

Year	2005	2006	2007	2008	2009	2010	2011	2012	2013
Non-Trauma	79,912	80,774	78,371	78,390	83,584	83,077	88,722	93,221	91,901

TOTAL - Adult & Pediatrics

Year	2014	2015	2016	2017	2018	2019	2020	2021	2022
Non-Trauma	93,521	95,169	96,847	98,554	100,291	102,059	103,858	105,689	107,552

Source: IDPH AHQ; Medical Center Financial Records

80V ACMC ED CON

11/4/2014 12:32 PM

148

Attachment 34
Clinical Services Areas
Emergency Department
Exhibit 4

Advocate Christ Medical Center Emergency Department
Projections, 2003 - 2022

Year	Actual Volume									
	2007	2008	2009	2010	2011	2012	2013	2014		
Non-Trauma	78,371	78,390	83,584	83,077	88,722	93,119	91,901	95,556		
Year	Projected Volume									
	2015	2016	2017	2018	2019	2020	2021	2022		
Non-Trauma	98,301	101,125	104,030	107,019	110,093	113,256	116,509	119,856		

Source: IDPH AHQ; Medical Center Financial Records
RY 2014 based on September 2013 to August 2014

Indicators that Drive the Need for the Number of Emergency Department Treatment Spaces

Indicator	Low Range You can estimate that your need for patient care spaces and overall department area will be in the LOW RANGE if the majority of the following parameters match what you believe your future department will be:	High Range You can estimate that your need for patient care spaces and overall department area will be in the HIGH RANGE if the majority of the following parameters match what you believe your future department will be:	Meets or Exceeds Indicator
Length of Stay	☐ Average total length of stay for all emergency department patients will be less than 2.5 hours. Because you'll have the ability to turn patient care spaces over quickly, you'll need fewer of them.	☒ Average total length of stay for all emergency department patients will be more than 3.5 hours. Because you won't be able to turn patient care spaces over quickly, you'll need more of them and, in turn, more clinical support spaces to support a larger department.	Yes
Location of Holding or Observation Beds (treatment sp)	☐ Your observation or evaluation unit or "admit holding" beds will be located <i>outside</i> of the emergency department, which will allow you to move patients out of the department for extended observation or for "holding" until they can be moved to inpatient units. Your emergency department can be at the lower range because you don't have to include these beds in your calculations.	☒ The observation, evaluation, and "admit holding" beds will be located within the department, which increases the number of patient care spaces and support areas you'll need.	Yes

Indicator	Low Range You can estimate that your need for patient care spaces and overall department area will be in the LOW RANGE if the majority of the following parameters match what you believe your future department will be:	High Range You can estimate that your need for patient care spaces and overall department area will be in the HIGH RANGE if the majority of the following parameters match what you believe your future department will be:	Meets or Exceeds Indicator
Time to Admit	☐ Emergency department patients who are admitted to the hospital will be transported out of the department less than 60 minutes after disposition. The ability to vacate the department allows you to turn patient care spaces over more quickly, which means that fewer spaces will be needed	☒ Emergency department patients who are admitted to the hospital will remain in the department more than 90 minutes after disposition. This extended stay will limit your ability to turn patient care spaces over quickly, which means that more spaces will be needed.	Yes
Turnaround time for diagnostic tests	☐ Average turnaround times for results from laboratory and imaging studies will be 30 minutes or less, which will enable you to turn patient care spaces over quickly.	☒ Average turn around times for results from laboratory and imaging studies will be more than 60 minutes, which will limit your ability to turn patient care spaces over quickly.	Partial Yes
Percentage of Patients Admitted	☐ Less than 18 percent of your emergency department patients will be admitted to the hospital. Having a lower-acuity patient population will allow for faster turnover of patient care spaces	☒ More than 23 percent of your emergency department patients will be admitted to the hospital. Having a higher-acuity patient population will require more time for diagnosis and treatment in the emergency department	Yes

Indicator	Low Range You can estimate that your need for patient care spaces and overall department area will be in the LOW RANGE if the majority of the following parameters match what you believe your future department will be:	High Range You can estimate that your need for patient care spaces and overall department area will be in the HIGH RANGE if the majority of the following parameters match what you believe your future department will be:	Meets or Exceeds Indicator
Percentage of non urgent vs. urgent patient presentations	☐ Non-urgent patients will outnumber urgent patients by more than 10 percent, which signifies a lower-acuity patient population.	☒ Urgent patients will outnumber non-urgent patients by more than 10 percent, which signifies a higher-acuity patient population and longer lengths of stay.	Yes
Age of patients	☒ Less than 20 percent of your patients will be older than 65 years.	☐ More than 25 percent of the patients will be older than 65 years. Older patients require more time and more diagnostic testing.	No
Need for Administrative or Teaching Spaces	☐ Your need for offices or teaching spaces within the emergency department will be minimal.	☒ Your need for teaching areas, faculty offices, and other administrative spaces within the emergency department will be extensive, such as in a university teaching hospital.	Yes
Imaging Services included within the emergency department	☐ Imaging studies will not be performed within the department.	☒ Imaging studies will be performed within the department.	Yes

Indicator	Low Range You can estimate that your need for patient care spaces and overall department area will be in the LOW RANGE if the majority of the following parameters match what you believe your future department will be:	High Range You can estimate that your need for patient care spaces and overall department area will be in the HIGH RANGE if the majority of the following parameters match what you believe your future department will be:	Meets or Exceeds Indicator
Specialty Components Pediatric Area	☐ You will not have a pediatric emergency department.	☒ APMC will have a pediatric emergency department that may require additional space for playroom studies, family areas, etc.	Yes
Specialty Components Psychiatric Patient Volume	☐ You will not have a large number of psychiatric patients.	☒ APMC's emergency case mix includes a high volume of psychiatric patients, which usually means that more patient care spaces will be needed.	Yes
Flight Services and/or Trauma services	☐ Flight services and trauma services support areas will not be included within the department.	☒ Flight services and trauma services support areas will be included within the department.	Yes

Figure 6.5.

High and low range estimates for department areas and bed quantities.

(Reproduced courtesy of FreemanWhite, Inc.)

Projected Annual Visits	Department Gross Area		Bed Quantities		High Range		Estimated Area/Bed	Estimated Observation/Clinical Decision (included in High Range Bed Quantities)
	Low Range Dept. Area	High Range Dept. Area	Low Range Bed Quantity	Low Range Visits/Bed	High Range Bed Quantity	High Range Visits/Bed		
10,000	7,200 dgsf	9,900 dgsf	8	1,250	11	909	900 dgsf/bed	2-3 patient spaces
20,000	13,500 dgsf	17,100 dgsf	15	1,333	19	1,053	900 dgsf/bed	3-4 patient spaces
30,000	17,500 dgsf	22,750 dgsf	20	1,500	26	1,154	875 dgsf/bed	4-6 patient spaces
40,000	21,875 dgsf	28,875 dgsf	25	1,600	33	1,212	875 dgsf/bed	6-8 patient spaces
50,000	25,500 dgsf	34,000 dgsf	30	1,667	40	1,250	850 dgsf/bed	8-10 patient spaces
60,000	29,750 dgsf	39,950 dgsf	35	1,714	47	1,277	850 dgsf/bed	9-12 patient spaces
70,000	33,000 dgsf	44,550 dgsf	40	1,750	54	1,296	825 dgsf/bed	11-14 patient spaces
80,000	37,125 dgsf	50,325 dgsf	45	1,778	61	1,311	825 dgsf/bed	13-16 patient spaces
90,000	40,000 dgsf	54,400 dgsf	50	1,800	68	1,324	800 dgsf/bed	14-18 patient spaces
100,000	44,000 dgsf	60,000 dgsf	55	1,818	75	1,333	800 dgsf/bed	16-20 patient spaces
110,000	46,500 dgsf	63,550 dgsf	60	1,833	82	1,341	775 dgsf/bed	18-22 patient spaces
120,000	50,375 dgsf	68,975 dgsf	65	1,846	89	1,348	775 dgsf/bed	20-24 patient spaces
130,000	52,500 dgsf	72,000 dgsf	70	1,857	96	1,354	750 dgsf/bed	22-26 patient spaces
140,000	56,250 dgsf	77,250 dgsf	75	1,867	103	1,359	750 dgsf/bed	24-28 patient spaces
150,000	58,000 dgsf	79,750 dgsf	80	1,875	110	1,364	725 dgsf/bed	26-30 patient spaces

Source: *American College of Emergency Physicians, Emergency Room Design (2002)*
Edited by Jon Huddy, AID

Clinical Service Areas

Inpatient Endoscopy (GI Labs)

Background

Nationally the diagnostic and treatment of gastrointestinal and bronchial disorders is moving to the outpatient setting. Even so, many endoscopy cases still require the back-up available in the inpatient setting, especially in a major medical center such as Advocate Christ Medical Center (ACMC, Medical Center) with tertiary programs related to the gastrointestinal disease.

ACMC is not expanding endoscopy labs as part of this project. The Medical Center is only proposing the number and location of the 10 endoscopy rooms approved in the Ambulatory Pavilion alteration (#11-019).

Historical Utilization of the Endoscopy Rooms, 2012 and 2013

Year	2012	2013	Percent Change
IP Hours	4,099	4,431	8.1
OP Hours	8,186	8,376	2.3
Total	12,285	12,807	4.2

Source: Medical Center Records.

c) Service Modernization

The applicant shall document that the proposed project meets one of the following:

1) Deteriorated Equipment or Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spend out of service due to operational failures, upkeep and annual maintenance costs, and licensure of fire code deficiency conditions involving the proposed project.

There are no code violations or life safety deficiencies in the inpatient endoscopy area.

However, with the relocation of outpatient endoscopy services to the Ambulatory Pavilion, this partially vacated space requires patient environment and work flow enhancements.

2) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic, treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

Need Based on 2012 and 2013 Utilization

Current utilization of the existing 10 existing endoscopy rooms justifies the need for 12 rooms.

2012

$$12,285 \text{ hours} \div 1,100 \text{ hours per rooms} = 12 \text{ rooms}$$

2013

$$12,807 \text{ hours} \div 1,100 \text{ hours per room} = 12 \text{ rooms}$$

Need Based on Future Utilization

In order to project future demand, the Medical Center prepared CAGR (compound average growth rate) trend lines based on utilization from 2006 to 2022. Because earlier data is not reliable, 2006 is the base year for the projections. Combined inpatient and outpatient growth suggests the need for 13 endoscopy rooms by 2022, the second full year of operation.

(See Attachment 34, Exhibit 1.)

CAGR Projected Endoscopy Hours, 2022

Year	2013	2022 (Second Full Year of Utilization)	Number of Rooms Justified @ 1,100 hours per room
IP Hours	4,431	5,463	5
OP Hours	8,376	12,460	12
Total	12,807	17,942	17

3) Utilization

A) Major Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months of acquisition.

NA There is no endoscopy equipment in this project that meets or exceeds the major medical equipment threshold.

B) Service or Facility

Projects involving the modernization of a service or facility shall meet or exceed the utilization standards for the service, as specified in Appendix B. The number of key rooms being modernized shall not exceed the number justified by historical utilization rates for each of the latest two years, unless additional key rooms can be justified per subsection c) 2) Necessary Expansion.

The Medical Center is currently operating 7 outpatient rooms in the Ambulatory Pavilion and conservatively is planning to modernize 3 inpatient rooms in the hospital – consistent with the approved 10-room complement approved in the Ambulatory Pavilion alteration.

The Medical Center justified the need for 17 endoscopy rooms by 2022 and is conservatively requesting 10, 3 of which will be modernized as part of the present Project.

Advocate Christ Medical Center Endoscopy Projections

Year	Actual Volume									
	2005	2006	2007	2008	2009	2010	2011	2012	2013	
Endoscopy Total Procedure Hours	-	9,915	10,919	11,334	11,274	13,273	11,076	12,285	12,807	
Inpatient Procedure Hours		3,765	4,054	3,884	3,827	4,305	3,728	4,099	4,431	
Outpatient Procedure Hours		6,150	6,865	7,450	7,447	8,968	7,348	8,186	8,376	

Year	Projected Volume									
	2014	2015	2016	2017	2018	2019	2020	2021	2022	
Endoscopy Total Procedure Hours	13,289	13,791	14,313	14,856	15,422	16,010	16,623	17,260	17,924	
Inpatient Procedure Hours	4,535	4,642	4,751	4,863	4,978	5,095	5,215	5,338	5,463	
Outpatient Procedure Hours	8,754	9,149	9,562	9,993	10,444	10,915	11,408	11,922	12,460	

Source: IDPH AHQ, Medical Center Financial Records

Clinical Service Areas
General Radiology

Background

An outcome of the Medical Center's Ambulatory Pavilion application (# 11-019) and the subsequent alteration, APMC was approved to operate 16 general radiology/fluoroscopy units. Of these, 9 are in the hospital's main imaging department, 1 is in Advocate Children's Hospital – Oak Lawn, 5 are in the Ambulatory Pavilion, and one is in a satellite location in Lockport. The Medical Center is proposing to add 2 new units in the Emergency Department. Today, approximately 48 percent of trauma and emergency patients require at least one general radiology exam. By having the units in the Emergency Department, transport times to the imaging equipment will reduce time to diagnosis and treatment and transport times to and from imaging department.

c) Service Modernization

The applicant shall document that the proposed project meets one of the following:

1) Deteriorated Equipment or Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and maintenance costs, and licensure of fire code deficiency conditions involving the proposed project.

There are no code violations or life safety deficiencies in the Imaging Department of Advocate Christ Medical Center (APMC, Medical Center).

The Medical Center is not proposing to replace equipment or facilities that have deteriorated.

The Medical Center is proposing to add 2 new general radiology units in vacated space in the expanded and modernized Emergency Department

2) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic, treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in scope of services offered, and licensure of fire code deficiency citations involving the proposed project.

During 2012 and 2013, the Medical Center's general radiology/fluoroscopy procedures were stable. The State Guideline for general radiology units is 8,000 procedures per unit

Historical Utilization of General Radiology/Fluoroscopy, 2012 and 2013

Year	2012	2013	Percent Change
IP Procedures	91,879	92,510	0.7
OP Procedures	63,110	60,681	-3.8
Total Procedures	154,989	153,191	-1.2
Number of Units	11	11	--
Procedures per Unit	14,090	13,926	-1.2

Note: 5 additional units were added when the Ambulatory Pavilion opened in March 2014.

Source: Medical Center Records

In 2012 and 2013, the general radiology units were operating at 75 percent higher than the State Guideline. This high utilization capped potential growth. Construction on the ACMC campus further detracted from potential growth.

When the new Ambulatory Pavilion opened in 2014, 5 additional general imaging units were added to the campus for a total of 16. Had these units been available in 2012 and 2013, the volume per unit would still have exceeded the State Guideline of 8,000 procedures per unit by 20 percent.

2012

$$154,989 \text{ 2012 procedures} \div 16 \text{ units} = 9,686 \text{ procedures per unit}$$

2013

$$153,191 \div 16 \text{ units} = 9,574 \text{ procedures per unit}$$

Need Based on Current Utilization

Current utilization of the Medical Center's general radiology/fluoroscopy units justifies the need for 20 general radiology units. The Medical Center has only 16 units; it could justify 4 additional units. The Medical Center is conservatively requesting only 2 additional units.

2012

$$154,989 \text{ procedures} \div 8,000 \text{ procedures per unit} = 20 \text{ units}$$

2013

$$153,191 \text{ procedures} \div 8,000 \text{ procedures per unit} = 20 \text{ units}$$

Need Based on Projected Utilization

To anticipate future demand, the Medical Center prepared CAGR trend lines based on utilization trends from 2005 to 2022, the second full year of operation of the remodeled and expanded Emergency Department.

This methodology suggests the Medical Center's continuing need for 20 general radiology units. (See Attachment 34, Exhibit 1.)

3) Utilization

A) Major Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

There is no major medical equipment as part of the general radiology expansion.

B) Service or Facility

Projects involving the modernization of a service or facility shall meet or exceed the utilization standards for the service as specified in Appendix B. The number of key rooms being modernized shall not exceed the number justified by historical utilization rates for each of the latest 2 years, unless additional key rooms can be justified per subsection c)

2) Necessary Expansion.

In Section c) 2) above, ACMC showed how the current utilization of the Medical Center's existing general fluoroscopy equipment is substantially higher than State Guidelines and justifies the need for 2 additional units.

The Medical Center is conservatively proposing to add 2 general radiology units in space in the remodeled Emergency Department. This will bring the total complement of general radiology units to 18 or fewer than the 20 units justified.

The addition of 2 general radiology units in the Emergency Department meets the "Necessary Expansion" criterion.

Advocate Christ Medical Center Imaging Projections

Year	Actual Volume									
	2005	2006	2007	2008	2009	2010	2011	2012	2013	
Radiology/Fluoroscopy Total (Campus + Lockport)	136,488	142,847	140,552	150,687	155,285	157,255	153,383	154,989	153,191	
CAGR										

Year	Projected Volume									
	2014	2015	2016	2017	2018	2019	2020	2021	2022	
Radiology/Fluoroscopy Total (Campus + Lockport)	155,418	157,677	159,969	162,294	164,653	167,046	169,475	171,938	174,437	
CAGR										

Source: IDPH AHQ, Medical Center Financial Records

Clinical Service Areas
Departments/Services without State Guidelines

Department/Area	2011	2012	2013
Trauma I/Resuscitation Center ¹	1,470	2,580	2,450
Triage	88,722	93,119	91,901
Phase I Recovery (PACU)	36,550	44,726	44,072
Phase II Recovery (Prep/Recovery)	65,616	51,400	51,118
Cast Room	1,672	3,155	3,055
TEE (Transesophageal Echo)	1,063	1,243	1,453
Ultrasound Mobile ²	NA	NA	NA

¹ Also see discussion of the Trauma I/Resuscitation Center in Attachment 34

² Requests for mobile ultrasound are not monitored. The Imaging Department estimates a range of from 6 to 15 requests per day, or from 2,190 to 5,475 requests per year.

Overview of Services with No Utilization Guidelines

Level I Trauma/Resuscitation Center

Advocate Christ Medical Center's designation as a Level I Trauma/Resuscitation Center (Trauma Center) for adults and children and its role as a Resource Hospital for EMS System Region VII are described at the beginning of Attachment 34.

The Medical Center's Trauma Center cares for the most critically ill and injured patients with a staff of 59 board certified emergency medicine physicians and specially credentialed nurses and emergency medicine techs. This very busy service serves a market that extends as far south as Kankakee, as far north as 58th Street in Chicago, as far west as Yorkville and Morris and much of Northwest Indiana.

As the only Level I Trauma Center in EMS System Region VI, the Medical Center is the Regional Health Care Coordination Center for the region; ACMC's role is to coordinate communication, education, medical direction and response, surge, and resources for local, county and statewide planned disaster exercises and actual disasters. The Medical Center is also the Chair of the Region VII Health Care Emergency Medicine Coalition, which includes multiple community partners (including 13 hospitals, police, fire, EMS, FBI, Red Cross and others). ACMC is also a National Disaster Management System (NDMS) hospital participant.

Triage

The Medical Center currently has 3 adult and 1 pediatric triage stations. At the completion of the proposed Project, there will be 5 stations. Triage is essentially an intake function and will be located at ground level in new construction. The triage registered nurse will register the patient, determine his complaint, and take a brief medical history. Triage is done to determine the severity of the patient's condition (so that the most urgent patients are seen by the physician first) and to immediately order appropriate tests (typically lab and imaging tests). After the brief triage visit, the patient is taken directly to an exam room, if one is available; otherwise the patient will be asked to wait in the reception area. The goal is to have lab and imaging test results ready by the time the physician sees the patient.

Phase I Recovery

Phase I recovery stations are needed for patients immediately after a procedure during which general anesthesia was administered. The number of Phase I recovery stations is determined by code, one Phase I recovery station is required for each procedure room. The Medical Center currently has and will continue to have 10 procedure rooms – 4 cardiac catheterization labs, 2 electrophysiology labs, 1 TEE room and 3 GI/Endoscopy labs. By code, one Phase I recovery room is required for each procedure rooms. All of the recovery stations supporting the cardiac catheterization and endoscopy labs are equipped to care for Phase I and Phase II patients; however, of the current total 19 stations, 10 are designated for Phase I patients.

Phase II Recovery

The 9 existing Phase II recovery stations are used by cardiac catheterization, electrophysiology, and TEE outpatients. These patients need a space to change into a hospital gown, to meet with their physicians and undergo any additional needed tests before their procedure. After their procedure, patients are stabilized and then monitored as they continue to recover, receive nourishment, and instruction on post discharge care in the Phase II recovery area. Since the Phase I and Phase II recovery areas at ACMC are similarly equipped, there is added flexibility of use in high census periods.

Cast Room

Physicians use the cast room to apply and remove casts for adult and pediatric patients. A cast is a shell (frequently made of plaster or synthetic materials such as knitted fiberglass bandages

impregnated with polyurethane) to encase limbs (and sometimes large portions of a body) to hold broken bones in place until healing is confirmed. There is currently a cast room in the Medical Center's Emergency Department, but it must be relocated to improve work flow in the department. The cast room is currently located in 966 DGSF; the proposed replacement cast room will be in 1,096 DGSF.

TEE (Transesophageal Echo)

During a transesophageal echo (TEE) procedure an ultrasound transducer, positioned on an endoscope, is guided down the patient's throat into the esophagus. The TEE test provides a close look at the heart's valves and chambers without interference from the ribs or lungs. The test is used to assess the overall function of the heart's valves and chambers, to determine the presence of any types of heart disease, evaluate the effectiveness of valve surgery and to evaluate abnormalities of the left atrium. TEE testing is currently done on the fourth floor of the hospital in the Stress Lab. It will be moved to the cardiac catheterization area on the first floor. The relocation is part of the proposed Project. The vacated space on the fourth floor will be used for storage. TEE testing is currently located in 191 DGSF; the proposed TEE room will be 248 DGSF.

Ultrasound – Mobile

Ultrasound is an imaging technology used to visualize subcutaneous body structures including tendons, muscles, breast and internal organs for possible pathology or lesions. Most ultrasound units are mobile and can be taken to the bedside. Ultrasound coverage for emergency patients is currently provided by the Imaging Department. Because of the frequent use of imaging equipment for emergency patients (approximately 10 percent of emergency patients require an ultrasound exam) and, because the emergency medical residency program is known for its exceptional training in ultrasound applications at the bed side, there will be 554 DGSF in the Emergency Department for a mobile unit.

The following Sections **DO NOT** need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18 month period prior to the submittal of the application):

- Section 1120.120 Availability of Funds – Review Criteria
- Section 1120.130 Financial Viability – Review Criteria
- Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)

VIII. - 1120.120 - Availability of Funds

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable: **Indicate the dollar amount to be provided from the following sources:**

29,467,082	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:
	1)	the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and
	2)	interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
56,052,000	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including:
	1)	For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated;
	2)	For revenue bonds, proof of the feasibility of securing the specified amount and interest rate;
	3)	For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.;
	4)	For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment;
	5)	For any option to lease, a copy of the option, including all terms and conditions.
_____	e)	Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
_____	f)	Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
85,519,082	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
TOTAL FUNDS AVAILABLE		

APPEND DOCUMENTATION AS **ATTACHMENT-36**, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Audited Financial Reports

The Consolidated Financial Statements and Supplementary Information for Advocate Health Care Network and Subsidiaries, Years Ended December 31, 2013 and 2012, with Report of Independent Auditors, are included with the CON Application #14-027 from Advocate BroMenn Medical Center, submitted July 3, 2014.

Bond Rating Letters

Bond rating letters from Fitch Ratings (AA), Moody's (Aa2) and Standard and Poors (AA/Stable) are included as Attachment 36, Exhibits 1, 2, and 3.

FitchRatings

One State Street Plaza
New York, NY 10004

T 212 908 0500 / 800 75 FITCH
www.fitchratings.com

July 12, 2013

Mr. Dominic Nakis
Senior Vice President, Chief Financial Officer
Advocate Health Care Network
3075 Highland Parkway
Downers Grove, IL 60515

Dear Mr. Nakis:

Fitch Ratings has assigned one or more ratings and/or otherwise taken rating action(s), as detailed in the attached Notice of Rating Action.

In issuing and maintaining its ratings, Fitch relies on factual information it receives from issuers and underwriters and from other sources Fitch believes to be credible. Fitch conducts a reasonable investigation of the factual information relied upon by it in accordance with its ratings methodology, and obtains reasonable verification of that information from independent sources, to the extent such sources are available for a given security or in a given jurisdiction.

The manner of Fitch's factual investigation and the scope of the third-party verification it obtains will vary depending on the nature of the rated security and its issuer, the requirements and practices in the jurisdiction in which the rated security is offered and sold and/or the issuer is located, the availability and nature of relevant public information, access to the management of the issuer and its advisers, the availability of pre-existing third-party verifications such as audit reports, agreed-upon procedures letters, appraisals, actuarial reports, engineering reports, legal opinions and other reports provided by third parties, the availability of independent and competent third-party verification sources with respect to the particular security or in the particular jurisdiction of the issuer, and a variety of other factors.

Users of Fitch's ratings should understand that neither an enhanced factual investigation nor any third-party verification can ensure that all of the information Fitch relies on in connection with a rating will be accurate and complete. Ultimately, the issuer and its advisers are responsible for the accuracy of the information they provide to Fitch and to the market in offering documents and other reports. In issuing its ratings Fitch must rely on the work of experts, including independent auditors with respect to financial statements and attorneys with respect to legal and tax matters. Further, ratings are inherently forward-looking and embody assumptions and predictions about future events that by their nature cannot be verified as facts. As a result, despite any verification of current facts, ratings can be affected by future events or conditions that were not anticipated at the time a rating was issued or affirmed.

Fitch seeks to continuously improve its ratings criteria and methodologies, and periodically updates the descriptions on its website of its criteria and methodologies for securities of a given type. The criteria and methodology used to determine a rating action are those in effect at the time the rating action is taken, which for public ratings is the date of the related rating action commentary. Each rating action commentary provides information about the criteria and methodology used to arrive at the stated rating, which may differ from the general criteria and methodology for the applicable security type posted on the website at a given time. For this reason, you should always consult the applicable rating action commentary for the most accurate information on the basis of any given public rating.

Ratings are based on established criteria and methodologies that Fitch is continuously evaluating and updating. Therefore, ratings are the collective work product of Fitch and no individual, or group of individuals, is solely responsible for a rating. All Fitch reports have shared authorship. Individuals identified in a Fitch report were involved in, but are not solely responsible for, the opinions stated therein. The individuals are named for contact purposes only.

Ratings are not a recommendation or suggestion, directly or indirectly, to you or any other person, to buy, sell, make or hold any investment, loan or security or to undertake any investment strategy with respect to any investment, loan or security or any issuer. Ratings do not comment on the adequacy of market price, the suitability of any investment, loan or security for a particular investor (including without limitation, any accounting and/or regulatory treatment), or the tax-exempt nature or taxability of payments made in respect of any investment, loan or security. Fitch is not your advisor, nor is Fitch providing to you or any other party any financial advice, or any legal, auditing, accounting, appraisal, valuation or actuarial services. A rating should not be viewed as a replacement for such advice or services.

The assignment of a rating by Fitch does not constitute consent by Fitch to the use of its name as an expert in connection with any registration statement or other filings under US, UK or any other relevant securities laws. Fitch does not consent to the inclusion of its ratings nor this letter communicating our rating action in any offering document.

It is important that you promptly provide us with all information that may be material to the ratings so that our ratings continue to be appropriate. Ratings may be raised, lowered, withdrawn, or placed on Rating Watch due to changes in, additions to, accuracy of or the inadequacy of information or for any other reason Fitch deems sufficient.

Nothing in this letter is intended to or should be construed as creating a fiduciary relationship between Fitch and you or between us and any user of the ratings.

In this letter, "Fitch" means Fitch, Inc. and Fitch Ratings Ltd and any subsidiary of either of them together with any successor in interest to any such person.

We are pleased to have had the opportunity to be of service to you. If we can be of further assistance, please feel free to contact us at any time.

Jeff Schaub
Managing Director, Operations
U.S. Public Finance /
Global Infrastructure & Project Finance

JS/mb

Enc: Notice of Rating Action
(Doc ID: 183651)

Notice of Rating Action

<u>Bond Description</u>	<u>Rating Type</u>	<u>Action</u>	<u>Rating</u>	<u>Outlook/ Watch</u>	<u>Eff Date</u>	<u>Notes</u>
Illinois Finance Authority (IL) (Advocate Health Care Network) rev bonds ser 2013	Long Term	New Rating	AA	RO:Sta	11-Jul-2013	
Key: RO: Rating Outlook, RW: Rating Watch; Pos: Positive, Neg: Negative, Sta: Stable, Evo: Evolving						

MOODY'S

INVESTORS SERVICE

Rating Action: Moody's assigns Aa2 to Advocate Health Care Network's \$75 million Series 2013A bonds; outlook stable

Global Credit Research - 11 Jul 2013

Aa2, Aa2/VMIG 1, and Aa2/P-1 ratings affirmed on \$1.2 billion of debt

New York, July 11, 2013 --

Moody's Rating

Issue: Revenue Bonds, Series 2013A; Rating: Aa2; Sale Amount: \$75,000,000; Expected Sale Date: 07/16/2013;
Rating Description: Revenue: Other

Opinion

Moody's Investors Service has assigned an Aa2 rating to Advocate Health Care Network's (Advocate) \$75 million of Series 2013A fixed rate bonds. The rating outlook remains stable. At this time, we are affirming the Aa2, Aa2/VMIG 1 and Aa2/P-1 ratings on Advocate's outstanding bonds.

SUMMARY RATINGS RATIONALE

The Aa2 long-term rating is based on Advocate's status as the largest system in the greater Chicago area with good geographic diversity and well positioned individual hospitals, sustained adequate operating margins, moderate debt levels driving exceptional debt measures, strong and growing investment portfolio, and nearly fully funded pension plan. The system's challenges include an increasingly competitive and consolidating healthcare market, moderate margins compared with Aa2 rated peers, and expected increases in capital spending, although at manageable levels relative to cashflow. Advocate's affiliation with Sherman Health Systems (rated Baa2 stable), effective June 1, 2013 and whereby Advocate became the sole corporate member of Sherman, has a minimal overall effect on Advocate's credit position; we view the addition of Sherman as positive strategically and moderately negative financially.

STRENGTHS

*Leading market position in greater Chicagoland with good geographic coverage and individual hospitals that maintain leading or prominent market shares in their local markets; geographic reach and diversification expanding with additions to system

*Consistent margins over the last several years with operating cashflow margins in the 9-10% range; in 2012, most hospitals were profitable

*Conservative and balanced approach to financing capital needs; debt measures based on fiscal year 2012 are strong with a low 30% debt-to-operating revenue, exceptional Moody's adjusted peak debt service coverage of over 10 times, and favorably low Moody's adjusted debt-to-cashflow of 2.0 times

*Strong and growing balance sheet position with 322 days of cash on hand at fiscal yearend 2012, providing a strong 270% coverage of debt

*Debt structure risks are manageable relative to cash and investments with over 500% cash-to-demand debt and over 300% monthly liquidity-to-demand debt based on fiscal year end 2012

*Strong management capabilities evidenced by the organization's historical ability to absorb operating challenges and continue to generate consistently solid absolute operating cashflow levels, meet or exceed operating budgets, execute strategies effectively including integrating newly acquired hospitals, and a commitment to very good disclosure practices

*Defined benefit pension plan is 92% funded relative to a pension benefit obligation (PBO) of \$835 million, consistent with a history of high funded levels

*Recent addition of Sherman Health Systems is positive strategically, expanding Advocate's presence in an attractive location with a brand new facility that is growing volumes and gaining market share from competitors; Sherman's high debt load has a moderate dilutive effect on Advocate's debt measures

CHALLENGES

*Operating income and operating cashflow margins are below similarly-rated peers, in part due to the system's close integration with a large number of physicians

*An increasingly competitive market for a number of Advocate's hospitals, with competitors expanding facilities, growing consolidation, and increasing competition for physicians

*Capital spending is anticipated to increase, although capital needs can be funded with cashflow and bond proceeds; the system has a history of closely managing capital spending relative to cashflow and adjusting to operating shortfalls if necessary

OUTLOOK

The stable outlook is based on the expectation that the system will continue to maintain solid operating performance and a strong market position and balance future capital spending and debt with cash flow and liquidity strength.

WHAT COULD MAKE THE RATING GO UP

Sustained and significant improvement in operating margins, growth in the system's size to provide greater geographic diversity

WHAT COULD MAKE THE RATING GO DOWN

Greater than expected increase in debt or unexpected and prolonged decline in operating performance; material weakening of balance sheet strength

The principal methodology used in this rating was Not-for-Profit Healthcare Rating Methodology published in March 2012. The additional methodology used in rating the short term underlying rating for bonds supported by self-liquidity was the Rating Methodology for Municipal Bonds and Commercial Paper Supported by a Borrower's Self-Liquidity published in January 2012. The additional methodology on which the short-term rating for bonds supported by bank SBPAs is based is Variable Rate Instruments Supported by Conditional Liquidity Facilities published in May 2013. Please see the Credit Policy page on www.moodys.com for a copy of this methodology.

REGULATORY DISCLOSURES

For ratings issued on a program, series or category/class of debt, this announcement provides certain regulatory disclosures in relation to each rating of a subsequently issued bond or note of the same series or category/class of debt or pursuant to a program for which the ratings are derived exclusively from existing ratings in accordance with Moody's rating practices. For ratings issued on a support provider, this announcement provides certain regulatory disclosures in relation to the rating action on the support provider and in relation to each particular rating action for securities that derive their credit ratings from the support provider's credit rating. For provisional ratings, this announcement provides certain regulatory disclosures in relation to the provisional rating assigned, and in relation to a definitive rating that may be assigned subsequent to the final issuance of the debt, in each case where the transaction structure and terms have not changed prior to the assignment of the definitive rating in a manner that would have affected the rating. For further information please see the ratings tab on the issuer/entity page for the respective issuer on www.moodys.com.

Regulatory disclosures contained in this press release apply to the credit rating and, if applicable, the related rating outlook or rating review.

Please see www.moodys.com for any updates on changes to the lead rating analyst and to the Moody's legal entity that has issued the rating.

Please see the ratings tab on the issuer/entity page on www.moodys.com for additional regulatory disclosures for each credit rating.

Lisa Martin

Senior Vice President
Public Finance Group
Moody's Investors Service, Inc.
250 Greenwich Street
New York, NY 10007
U.S.A.
JOURNALISTS: 212-553-0376
SUBSCRIBERS: 212-553-1653

Mark Pascaris
Vice President - Senior Analyst
Public Finance Group
JOURNALISTS: 212-553-0376
SUBSCRIBERS: 212-553-1653

Releasing Office:
Moody's Investors Service, Inc.
250 Greenwich Street
New York, NY 10007
U.S.A.
JOURNALISTS: 212-553-0376
SUBSCRIBERS: 212-553-1653

MOODY'S INVESTORS SERVICE

© 2014 Moody's Corporation, Moody's Investors Service, Inc., Moody's Analytics, Inc. and/or their licensors and affiliates (collectively, "MOODY'S"). All rights reserved.

CREDIT RATINGS ISSUED BY MOODY'S INVESTORS SERVICE, INC. ("MIS") AND ITS AFFILIATES ARE MOODY'S CURRENT OPINIONS OF THE RELATIVE FUTURE CREDIT RISK OF ENTITIES, CREDIT COMMITMENTS, OR DEBT OR DEBT-LIKE SECURITIES, AND CREDIT RATINGS AND RESEARCH PUBLICATIONS PUBLISHED BY MOODY'S ("MOODY'S PUBLICATION") MAY INCLUDE MOODY'S CURRENT OPINIONS OF THE RELATIVE FUTURE CREDIT RISK OF ENTITIES, CREDIT COMMITMENTS, OR DEBT OR DEBT-LIKE SECURITIES. MOODY'S DEFINES CREDIT RISK AS THE RISK THAT AN ENTITY MAY NOT MEET ITS CONTRACTUAL, FINANCIAL OBLIGATIONS AS THEY COME DUE AND ANY ESTIMATED FINANCIAL LOSS IN THE EVENT OF DEFAULT. CREDIT RATINGS DO NOT ADDRESS ANY OTHER RISK, INCLUDING BUT NOT LIMITED TO: LIQUIDITY RISK, MARKET VALUE RISK, OR PRICE VOLATILITY. CREDIT RATINGS AND MOODY'S OPINIONS INCLUDED IN MOODY'S PUBLICATIONS ARE NOT STATEMENTS OF CURRENT OR HISTORICAL FACT. MOODY'S PUBLICATIONS MAY ALSO INCLUDE QUANTITATIVE MODEL-BASED ESTIMATES OF CREDIT RISK AND RELATED OPINIONS OR COMMENTARY PUBLISHED BY MOODY'S ANALYTICS, INC. CREDIT RATINGS AND MOODY'S PUBLICATIONS DO NOT CONSTITUTE OR PROVIDE INVESTMENT OR FINANCIAL ADVICE, AND CREDIT RATINGS AND MOODY'S PUBLICATIONS ARE NOT AND DO NOT PROVIDE RECOMMENDATIONS TO PURCHASE, SELL, OR HOLD PARTICULAR SECURITIES. NEITHER CREDIT RATINGS NOR MOODY'S PUBLICATIONS COMMENT ON THE SUITABILITY OF AN INVESTMENT FOR ANY PARTICULAR INVESTOR. MOODY'S ISSUES ITS CREDIT RATINGS AND PUBLISHES MOODY'S PUBLICATIONS WITH THE EXPECTATION AND UNDERSTANDING THAT EACH INVESTOR WILL, WITH DUE CARE, MAKE ITS OWN STUDY AND EVALUATION OF EACH SECURITY THAT IS UNDER CONSIDERATION FOR PURCHASE, HOLDING, OR SALE.

MOODY'S CREDIT RATINGS AND MOODY'S PUBLICATIONS ARE NOT INTENDED FOR USE BY RETAIL INVESTORS AND IT WOULD BE RECKLESS FOR RETAIL INVESTORS TO CONSIDER MOODY'S CREDIT RATINGS OR MOODY'S PUBLICATIONS IN MAKING ANY INVESTMENT DECISION. IF IN DOUBT YOU SHOULD CONTACT YOUR FINANCIAL OR OTHER PROFESSIONAL ADVISER.

ALL INFORMATION CONTAINED HEREIN IS PROTECTED BY LAW, INCLUDING BUT NOT LIMITED TO, COPYRIGHT LAW, AND NONE OF SUCH INFORMATION MAY BE COPIED OR OTHERWISE REPRODUCED, REPACKAGED, FURTHER TRANSMITTED, TRANSFERRED, DISSEMINATED, REDISTRIBUTED OR RESOLD, OR STORED FOR SUBSEQUENT USE FOR ANY SUCH PURPOSE, IN WHOLE OR IN PART, IN ANY FORM OR MANNER OR BY ANY MEANS WHATSOEVER, BY ANY PERSON WITHOUT MOODY'S PRIOR WRITTEN CONSENT.

All information contained herein is obtained by MOODY'S from sources believed by it to be accurate and reliable. Because of the possibility of human or mechanical error as well as other factors, however, all information contained herein is provided "AS IS" without warranty of any kind. MOODY'S adopts all necessary measures so that the information it uses in assigning a credit rating is of sufficient quality and from sources MOODY'S considers to be reliable including, when appropriate, independent third-party sources. However, MOODY'S is not an auditor and cannot in every instance independently verify or validate information received in the rating process or in preparing the Moody's Publications.

To the extent permitted by law, MOODY'S and its directors, officers, employees, agents, representatives, licensors and suppliers disclaim liability to any person or entity for any indirect, special, consequential, or incidental losses or damages whatsoever arising from or in connection with the information contained herein or the use of or inability to use any such information, even if MOODY'S or any of its directors, officers, employees, agents, representatives, licensors or suppliers is advised in advance of the possibility of such losses or damages, including but not limited to: (a) any loss of present or prospective profits or (b) any loss or damage arising where the relevant financial instrument is not the subject of a particular credit rating assigned by MOODY'S.

To the extent permitted by law, MOODY'S and its directors, officers, employees, agents, representatives, licensors and suppliers disclaim liability for any direct or compensatory losses or damages caused to any person or entity, including but not limited to by any negligence (but excluding fraud, willful misconduct or any other type of liability that, for the avoidance of doubt, by law cannot be excluded) on the part of, or any contingency within or beyond the control of, MOODY'S or any of its directors, officers, employees, agents, representatives, licensors or suppliers, arising from or in connection with the information contained herein or the use of or inability to use any such information.

NO WARRANTY, EXPRESS OR IMPLIED, AS TO THE ACCURACY, TIMELINESS, COMPLETENESS, MERCHANTABILITY OR FITNESS FOR ANY PARTICULAR PURPOSE OF ANY SUCH RATING OR OTHER OPINION OR INFORMATION IS GIVEN OR MADE BY MOODY'S IN ANY FORM OR MANNER WHATSOEVER.

MIS, a wholly-owned credit rating agency subsidiary of Moody's Corporation ("MCO"), hereby discloses that most issuers of debt securities (including corporate and municipal bonds, debentures, notes and commercial paper) and preferred stock rated by MIS have, prior to assignment of any rating, agreed to pay to MIS for appraisal and rating services rendered by it fees ranging from \$1,500 to approximately \$2,500,000. MCO and MIS also maintain policies and procedures to address the independence of MIS's ratings and rating processes. Information regarding certain affiliations that may exist between directors of MCO and rated entities, and between entities who hold ratings from MIS and have also publicly reported to the SEC an ownership interest in MCO of more than 5%, is posted annually at www.moodys.com under the heading "Shareholder Relations — Corporate Governance — Director and Shareholder Affiliation Policy."

For Australia only: Any publication into Australia of this document is pursuant to the Australian Financial Services License of MOODY'S affiliate, Moody's Investors Service Pty Limited ABN 61 003 399 657 AFSL 336969 and/or Moody's Analytics Australia Pty Ltd ABN 94 105 136 972 AFSL 383569 (as applicable). This document is intended to be provided only to "wholesale clients" within the meaning of section 761G of the Corporations Act 2001. By continuing to access this document from within Australia, you represent to MOODY'S that you are, or are accessing the document as a representative of, a "wholesale client" and that neither you nor the entity you represent will directly or indirectly disseminate this document or its contents to "retail clients" within the meaning of section 761G of the Corporations Act 2001. MOODY'S credit rating is an opinion as to the creditworthiness of a debt obligation of the issuer, not on the equity securities of the issuer or any form of security that is available to retail clients. It would be dangerous for "retail clients" to make any investment decision based on MOODY'S credit rating. If in doubt you should contact your financial or other professional adviser.



Research

Summary:

Illinois Finance Authority Advocate Health Care Network; System

10-Jul-2013

Current Ratings

Credit Profile

US\$75.0 mil hosp rev bnds (Advocate Hth Care Network) ser 2013A due 08/01/2043

Long Term Rating

AA/Stable

New

Rationale

Standard & Poor's Ratings Services assigned its 'AA' long-term rating to the Illinois Finance Authority's \$75 million series 2013A fixed-rate bonds issued for Advocate Health Care Network (AHCN). Standard & Poor's also affirmed its 'AA' long-term rating and, where applicable, its 'AA/A-1+' and 'AA/A-1' ratings on various other series of bonds issued by the authority on behalf of AHCN. The outlook on all ratings is stable.

The 'A-1+' short-term component of the rating on the series 2003A, 2003C, and 2008C-3B mandatory tender bonds and 2011B windows bonds reflects the credit strength inherent in the 'AA' long-term rating on AHCN's debt and the sufficiency of AHCN's unrestricted assets to provide liquidity support for the aforementioned bonds. Standard & Poor's Fund Ratings and Evaluations Group assesses the liquidity of AHCN's unrestricted investment portfolio to determine the adequacy and availability of these funds to guarantee the timely purchase of the bonds tendered in the event of a failed remarketing. We monitor the liquidity and sufficiency of AHCN's investment portfolio on a monthly basis.

The 'A-1+' short-term component of the rating on the issuer's series 2008C-2A and 2008C-3A bonds and the 'A-1' short-term component of the rating on the series 2008C-1 and 2008C-2B bonds reflect the standby bond purchase agreements (SBPAs) in effect from various financial institutions. They further reflect our view of the likelihood of payment of tenders and our view of liquidity facilities that cover all of the bond series. For more information, see the Financial Profile section.

As of June 1, 2013, Sherman Health Systems completed an affiliation with AHCN. As part of this affiliation, Sherman Health Systems (the parent) was dissolved and merged into Sherman Hospital and the hospital's name was changed to Advocate Sherman Hospital. Over the next month, AHCN anticipates redeeming Advocate Sherman's \$105 million series 1997 bonds and is evaluating a tender offer for Advocate Sherman's remaining \$170 million series 2007A bonds. If the series 2007A bonds are refinanced (or redeemed), Advocate Sherman will become part of AHCN's obligated group. Otherwise, Advocate Sherman's series 2007A bonds will remain obligations of Advocate Sherman only.

The 'AA' long-term rating reflects our view of AHCN's strength as the Chicago area's largest health system (with total operating revenue of \$4.6 billion in 2012 and a balance sheet with \$7.8 billion of total assets) as well as its good operating performance, strong and consistent coverage, and stable and healthy unrestricted reserves with moderate debt for the rating. In addition, AHCN's strong physician relationships and practice in managing care under capitated risk and through shared savings programs, including the Medicare accountable care organization demonstration project, are credit strengths in light of some of the anticipated changes related to health care reform. Given the Sherman transaction

<https://www.globalcreditportal.com/ratingsdirect/showArticlePage.do?rand=fu66e3TVrs&...> 6/26/2014

as well as increased capital spending during the next few years, we anticipate possible declines in operational liquidity and in absolute levels of reserves, but within the range of medians for the rating. Although the series 2013A new money debt was not anticipated, it's absorbable at the current rating given AHCN's balance sheet strength and historically good cash flow and healthy pro forma coverage. We are seeing signs of operating margin pressure, as more one-time items supported revenue last year, and we believe AHCN's focus on managing expenses and backfilling volumes that may be lost as a result of lower utilization (linked to both better care management and fewer readmissions) is important to maintaining health cash flow and coverage levels.

The 'AA' long-term rating further reflects our view of AHCN's:

- Good financial profile, with operating margins of more than 4% for the past four years but with a slightly lighter unaudited operating margin of 2.7% through the first three months of fiscal 2013, and consistently strong pro forma maximum annual debt service (MADS) coverage of 6x or greater for the past several years (although Advocate Sherman's coverage is weaker, it is in the 2x area);
- Robust balance sheet measures, as demonstrated by still light pro forma leverage of 25% and by solid unrestricted reserves of 330 days' cash on hand and unrestricted reserves to pro forma debt of 261% as of March 31, 2013 (balance sheet ratios will be diluted slightly as Advocate Sherman's financials are incorporated into the credit profile, but will remain within the range of medians for the rating);
- Incremental growth in AHCN's leading market share through 2012, to 16.2% (which will likely increase with the Sherman merger complete); and
- Position as Chicago's largest and most successfully integrated health delivery system, with approximately 3,200 licensed beds and more than 5,600 physicians, 4,150 of whom are affiliated with Advocate Physician Partners, a joint venture between AHCN and clinically and financially aligned physicians with the purpose of providing cost-effective health care to patients in the communities AHCN serves.

Partly offsetting the above strengths, in our view, are:

- AHCN's very strong competition in the greater Chicago market -- other systems and large academic medical centers -- coupled with volume pressures related to both industry and economic issues as well as health care reform;
- Market consolidation that could affect AHCN as an acquirer or with new ownership at a competing facility; and
- AHCN's heightened capital spending during the next few years as a few major projects are started and completed, which could dampen unrestricted reserve growth during the short term.

Total long-term debt at Dec. 31, 2012 was \$1.4 billion, which includes about \$38 million of capital leases and other loans. Including Advocate Sherman debt and the series 2013A transaction, pro forma long-term debt increases to approximately \$1.6 billion. This includes debt classified on the audited financial statements as a current liability subject to short-term remarketing agreements, which we treat as long-term debt for the purpose of our debt-related ratios. AHCN's rated bonds are the general, unsecured joint, and several obligations of the obligated group, which consists of the parent, AHCN; Advocate Health and Hospitals Corp., which includes most of AHCN's acute care facilities; Advocate North Side Health Network, which includes Advocate Illinois Masonic Center; and Advocate Condell Medical Center. However, this analysis reflects the system as a whole.

The \$75 million series 2013A proceeds, along with about \$25 million proceeds of series 2013B bonds that will be issued during the next month or two, will be used for future capital spending on a variety of projects during the next few years. These projects were included in AHCN's capital forecasts and are not new. The series 2013B bonds will likely be issued as variable rate, but the exact structure is still being determined.

For more information see our full analysis published July 10, 2013 on RatingsDirect.

<https://www.globalcreditportal.com/ratingsdirect/showArticlePage.do?rand=fu66e3TVrs&...> 6/26/2014

Outlook

The stable outlook reflects our view of AHCN's continued market leadership, extensive physician network, and solid financial profile. Given the heightened capital spending during the next few years and industry pressures that could dampen AHCN's healthy margins, a higher rating is unlikely.

However, we could consider raising the rating if management maintains strong operations and unrestricted reserves of roughly 325 days' cash on hand after the higher levels of capital spending during the next few years (as the service area is highly competitive).

Given our view of AHCN's strong market position, consistent financial profile, and good financial flexibility, we are also unlikely to lower the rating during the next year or two. However, we could consider lowering the rating if AHCN's debt service coverage declines to and remains at approximately 4x or if unrestricted reserves decrease to and stabilize at about 200 days' cash. We do not anticipate any additional new money debt issuances during the next one to two years.

Related Criteria And Research

- USPF Criteria: Not-For-Profit Health Care, June 14, 2007
- USPF Criteria: Contingent Liquidity Risks, March 5, 2012
- USPF Criteria: Commercial Paper, VRDO, And Self-Liquidity, July 3, 2007
- USPF Criteria: Bank Liquidity Facilities, June 22, 2007

Ratings Detail (As Of 10-Jul-2013)

Illinois Fin Auth, Illinois

Advocate Hlth Care Network, Illinois

Illinois Fin Auth (Advocate Hlth Care Network) hosp rev bnds (Advocate Hlth Care Network), 2008A-1/A-2/A-3

<i>Long Term Rating</i>	AA/Stable	Affirmed
-------------------------	-----------	----------

Illinois Fin Auth (Advocate Hlth Care Network) var rate dem bnds (Advocate Hlth Care Network) ser 2008C-2A dtd 04/23/2008 due 11/01/2038

<i>Long Term Rating</i>	AA/A-1+/Stable	Affirmed
-------------------------	----------------	----------

Series 2003A & C, 2008C-3B, 2011B windows

<i>Long Term Rating</i>	AA/A-1+/Stable	Affirmed
-------------------------	----------------	----------

Series 2008D, 2010A-D, 2011A & 2012

<i>Long Term Rating</i>	AA/Stable	Affirmed
-------------------------	-----------	----------

Series 2008C-1, 2008C-2B

<i>Long Term Rating</i>	AA/A-1/Stable	Affirmed
-------------------------	---------------	----------

Series 2008C-3A

<i>Long Term Rating</i>	AA/A-1+/Stable	Affirmed
-------------------------	----------------	----------

Complete ratings information is available to subscribers of RatingsDirect at www.globalcreditportal.com. All ratings affected by this rating action can be found on Standard & Poor's public Web site at www.standardandpoors.com. Use the Ratings search box located in the left column.

Primary Credit Analyst: Suzie R Desai, Chicago (1) 312-233-7046; suzie.desai@standardandpoors.com

Secondary Contact: Brian T Williamson, Chicago (1) 312-233-7009; brian.williamson@standardandpoors.com

No content (including ratings, credit-related analyses and data, valuations, model, software or other application or output therefrom) or any part thereof (Content) may be modified, reverse engineered, reproduced or distributed in any form by any means, or stored in

<https://www.globalcreditportal.com/ratingsdirect/showArticlePage.do?rand=fu66e3TVrs&...> 6/26/2014

a database or retrieval system, without the prior written permission of Standard & Poor's Financial Services LLC or its affiliates (collectively, S&P). The Content shall not be used for any unlawful or unauthorized purposes. S&P and any third-party providers, as well as their directors, officers, shareholders, employees or agents (collectively S&P Parties) do not guarantee the accuracy, completeness, timeliness or availability of the Content. S&P Parties are not responsible for any errors or omissions (negligent or otherwise), regardless of the cause, for the results obtained from the use of the Content, or for the security or maintenance of any data input by the user. The Content is provided on an "as is" basis. S&P PARTIES DISCLAIM ANY AND ALL EXPRESS OR IMPLIED WARRANTIES, INCLUDING, BUT NOT LIMITED TO, ANY WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE OR USE, FREEDOM FROM BUGS, SOFTWARE ERRORS OR DEFECTS, THAT THE CONTENTS FUNCTIONING WILL BE UNINTERRUPTED, OR THAT THE CONTENT WILL OPERATE WITH ANY SOFTWARE OR HARDWARE CONFIGURATION. In no event shall S&P Parties be liable to any party for any direct, indirect, incidental, exemplary, compensatory, punitive, special or consequential damages, costs, expenses, legal fees, or losses (including, without limitation, lost income or lost profits and opportunity costs or losses caused by negligence) in connection with any use of the Content even if advised of the possibility of such damages.

Credit-related and other analyses, including ratings, and statements in the Content are statements of opinion as of the date they are expressed and not statements of fact. S&P's opinions, analyses, and rating acknowledgment decisions (described below) are not recommendations to purchase, hold, or sell any securities or to make any investment decisions, and do not address the suitability of any security. S&P assumes no obligation to update the Content following publication in any form or format. The Content should not be relied on and is not a substitute for the skill, judgment and experience of the user, its management, employees, advisors and/or clients when making investment and other business decisions. S&P does not act as a fiduciary or an investment advisor except where registered as such. While S&P has obtained information from sources it believes to be reliable, S&P does not perform an audit and undertakes no duty of due diligence or independent verification of any information it receives.

To the extent that regulatory authorities allow a rating agency to acknowledge in one jurisdiction a rating issued in another jurisdiction for certain regulatory purposes, S&P reserves the right to assign, withdraw, or suspend such acknowledgment at any time and in its sole discretion. S&P Parties disclaim any duty whatsoever arising out of the assignment, withdrawal, or suspension of an acknowledgment as well as any liability for any damage alleged to have been suffered on account thereof.

S&P keeps certain activities of its business units separate from each other in order to preserve the independence and objectivity of their respective activities. As a result, certain business units of S&P may have information that is not available to other S&P business units. S&P has established policies and procedures to maintain the confidentiality of certain nonpublic information received in connection with each analytical process.

S&P may receive compensation for its ratings and certain analyses, normally from issuers or underwriters of securities or from obligors. S&P reserves the right to disseminate its opinions and analyses. S&P's public ratings and analyses are made available on its Web sites, www.standardandpoors.com (free of charge), and www.ratingsdirect.com and www.globalcreditportal.com (subscription) and www.spcapitaliq.com (subscription) and may be distributed through other means, including via S&P publications and third-party redistributors. Additional information about our ratings fees is available at www.standardandpoors.com/usratingsfees.

Any Passwords/user IDs issued by S&P to users are single user-dedicated and may ONLY be used by the individual to whom they have been assigned. No sharing of password/user IDs and no simultaneous access via the same password/user ID is permitted. To reprint, translate, or use the data or information other than as provided herein, contact Client Services, 55 Water Street, New York, NY 10041; (1) 212-438-7280 or by e-mail to: research_request@standardandpoors.com.

Copyright © 2014 Standard & Poor's Financial Services LLC, a part of McGrawHill Financial. All Rights Reserved.

<https://www.globalcreditportal.com/ratingsdirect/showArticlePage.do?rand=fu66e3TVrs&...> 6/26/2014

IX. **1120.130 - Financial Viability**

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

1. "A" Bond rating or better
2. All of the projects capital expenditures are completely funded through internal sources
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
4. The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT-37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

NA. Advocate Health Care Network has an A Bond rating.

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which **audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion.** When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

Provide Data for Projects Classified as:	Category A or Category B (last three years)			Category B (Projected)
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

2. Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 38, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

NA. Advocate Health Care Network has an A Bond rating.

X. 1120.140 - Economic Feasibility**A. Reasonableness of Financing Arrangements** NA Advocate Health has an A bond rating

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

- 1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or
- 2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:
 - A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
 - B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

- 1) That the selected form of debt financing for the project will be at the lowest net cost available;
- 2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;
- 3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment. **See Attachment 39, Exhibit 1**

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. \$ (A x C)	Mod. \$ (B x E)	
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

APPEND DOCUMENTATION AS ATTACHMENT -39, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Cost and Gross Square Feet by Department or Service												
	A	B	C	D	E	F	G	H		Total Cost		
	Cost / Square Foot		Gross Square Feet		Gross Square Feet		Const. Cost	Mod. Cost				
	New	Mod.	New	Circ. %	Mod.	Circ.	(AxC)	(BxE)				
Department												
Clinical												
Trauma		\$ 489.67			7,342			\$ 3,595,192.27			3,595,192	
Triage	\$ 394.49		1,447				570,821			570,821	570,821	
Emergency Department Adult		\$ 498.82			22,737			11,341,726.05			11,341,726	
Emergency Department Pediatric		\$ 455.81			13,324			6,073,268.75			6,073,269	
Phase 1 Recovery		\$ 390.24			1,751			683,302.07			683,302	
Phase 2 Recovery		\$ 390.24			8,184			3,193,685.99			3,193,686	
GI/Endoscopy		\$ 595.91			2,672			1,592,270.39			1,592,270	
Cast Room		\$ 546.49			130			71,044.24			71,044	
General Radiology		\$ 271.10			1,910			517,809.43			517,809	
Ultra sound Mobile		\$ 654.10			554			362,371.61			362,372	
TEE		\$ 525.38			248			130,295.09			130,295	
Clinical / Average Cost / Sq. Ft.	\$ 394.49	\$ 468.31	1,447		58,852		\$570,821	\$ 27,560,965.89			\$28,131,787	
Contingency (%) (9.95% New const., 14.95 % modifications)	39.25	70.01					56,796.66	4,120,364.40			4,177,161.06	
Clinical Subtotal / Average Cost / Sq. Ft.	\$ 433.74	\$ 538.32					\$627,617	\$ 31,681,330.29			32,308,948	
Non-Clinical												
Admin	\$ 413.23	\$ 208.33	625		7,670		258,268	\$ 1,597,875.08			1,856,143	
Public spaces	\$ 349.53	\$ 457.69	4,518		1,562		1,579,162	\$ 714,909.79			2,294,072	
Building Components	\$ 358.97	\$ 952.35	2,245		1,429		805,894	\$ 1,360,908.00			2,166,802	
Non-Clinical / Average Cost / Sq. Ft.	\$357.79	\$ 344.59	7,388		10,661		\$2,643,324	\$ 3,673,692.88			\$6,317,017	
Contingency (%) (9.95% New const., 14.95 % modifications)	\$ 35.60	\$ 51.52					\$263,011	\$ 549,217.09			\$812,228	
Non Clinical Subtotal / Average Cost / Sq. Ft.	\$393.39	\$396.11					\$2,906,335	\$ 4,222,909.96			7,129,245	
Total with Contingency/Average Cost/Sq. Ft.	\$ 503.37										39,438,192	

Attached as Exhibits 2 and 3 are letters from HDR, the Project architect, and Pepper Construction Company, describing factors that incur costs not normally anticipated in average cost per square foot for modernization projects with less complicated clinical and operational challenges. Some of these factors include:

- The staging of construction in the sensitive Trauma Center and Emergency Department environment. The expansion of these departments while maintaining existing operations will necessitate staging of construction in approximately seven major phases. Each phase will require mobilization and demobilization of construction forces before proceeding to the next phase, thereby limiting the efficiency of the workforce.
- The architectural plan efficiency limitations imposed by existing building conditions.
- The outfitting of the Trauma Center and Emergency Department to handle potential pandemic events.
- Strict requirements for life safety measures including substantial additional costs for temporary barriers to protect patients and staff from construction areas.
- The expansion/modernization project is in an area comprised of several additions built over many years with varying structural, mechanical and electrical systems. The varying structural systems' column locations, the varying floor elevations, and the need to maintain internal circulation, and to work around existing mechanical shafts add construction costs.
- Moreover, areas that formerly were not patient treatment space will require modifications to existing mechanical, electrical and structural systems to bring them up to current code requirements. Multiple system shut-downs and tie-ins will also add cost.
- The creation of a new Emergency Department main entrance at grade inside the existing parking garage including the interim handling of site utilities. Existing below grade plumbing/ utilities will need to be demolished to accommodate building excavation and foundation elements, but cannot be re-established permanently until the new structure and piping are installed.

- There are numerous utility mains that are routed through areas of renovation that serve adjacent modalities that will need to remain uninterrupted. As a result of the new piping and ductwork routing temporary ductwork and piping will need to be installed to facilitate the installation of new ductwork without affecting the adjacent occupied hospital modalities.
- The strategic and measured use of off-hours labor will be required. In addition, afterhours access to existing occupied hospital modalities, not scheduled for renovation, will also be required.
- Elevators being added to the center core of the Emergency Department to transport patients from the ground level entry to the Department will require extensive structural work to the existing building in order to create the new shafts. Further, existing utilities will also need to be relocated in order to create the new shafts without affecting hospital operations.

4440 West 95th Street
Oak Lawn, Illinois 60453
Telephone 708.684.8000
www.advocatehealth.com



October 17, 2014

Ms. Courtney Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

Dear Ms. Avery:

The purpose of this letter is to attest to the fact that the selected form of debt financing for the proposed Advocate Christ Medical Center Trauma Center/Emergency Department expansion and modernization project will be the lowest net cost available, of if a more costly form of financing is selected, that form is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional debt, term financing costs, and other factors. Generally, the term of the indebtedness is anticipated to be twenty years but would not exceed forty years and the interest rate approximately 5.5 percent, but not to exceed 6.5 percent.

Sincerely,

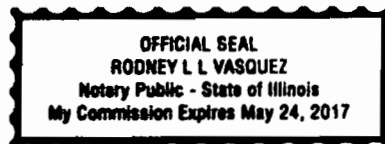
A handwritten signature in cursive script, appearing to read "Ken Lukhard".

Kenneth Lukhard
President

Subscribed and sworn before me on this 16th day of October, 2014.

A handwritten signature in cursive script, appearing to read "Rodney L. Vasquez".
Signature of Notary

Seal of Notary



Related to the Evangelical Lutheran Church in America and the United Church of Christ

Recipient of the Magnet award for excellence in nursing services by the American Nurses Credentialing Center





October 14, 2014

Ms. Nancy Dolan
Planning and Design Manager
Planning, Design and Construction
Advocate Health Care
3075 Highland Parkway, Suite 600
Downers Grove, IL 60515

Re: Advocate Christ Medical Center, Oak Lawn, IL
Emergency Department Expansion and Renovation, Inpatient G.I. and Cath Lab Prep and Recovery Suite
Renovation project
Architectural Impediments
HDR Project No. 223162

Dear Nancy,

Per your request, we have evaluated the probable construction costs anticipated for the expansion and renovation of the existing Emergency Department at Advocate Christ Medical Center to increase capacity to serve additional patients, while maintaining the delivery of existing Emergency Department patient services in a highly sensitive environment.

It is anticipated that the project will incur additional costs above current typical costs per square foot averages due to the staging of construction activities in the sensitive Emergency Department environment, to the architectural plan efficiency limitations imposed by existing building conditions, as well as to the outfitting of the Emergency Department as a Level 1 Trauma Center with the capacity to handle potential pandemic events. These impediments have increased the anticipated construction cost of the Emergency Department Expansion and Renovation project beyond the average cost for a less complicated project.

The expansion of this Level 1 Trauma Center Emergency Department within a finite hospital building footprint, while maintaining existing operations, will necessitate the staging of construction in approximately seven major phases. This will require multiple "checkerboard" moves of space, to make room for the relocation of Emergency Department support spaces, Cath Lab Prep and Recovery and Inpatient GI rooms, where necessary to make room for expanded ED exam and resuscitation rooms. Each of the phases will require the mobilization and demobilization of construction forces before proceeding to the next phase, limiting the efficiency of the work force and increasing costs. Strict requirements for fire safety, infection control and acoustical control during each phase will require extensive interim life safety measures undertaken with each phase, including substantial additional costs for temporary barriers to protect hospital patients and staff from construction areas, increasing construction costs.

The additional ED capacity requires expansion and renovation in an area of the hospital comprised of several additions built over many years, with varying structural, mechanical and electrical systems. The varying structural systems' column locations, and varying floor elevations have limited the efficiency of the plan layout. Further complicating the plan is the need to maintain internal circulation paths between existing inpatient bed tower elevators and the Imaging Department, and to work around existing mechanical shafts and closets. Areas that formerly were not patient treatment space, will require modifications to the existing mechanical, electrical and structural systems to bring them up to current code requirements. Multiple system shut-downs and tie-ins will add additional costs.

Due to its complexity, it is expected that this project will incur additional costs not normally anticipated in average costs per square foot for similar types of space.

Sincerely,

Mark Balasi, Licensed Architect
HDR Architecture, Chicago, IL



October 14, 2014

RE: Advocate Christ Medical Center
Emergency Department Renovations & Backfill

To Whom It May Concern:

Regarding the subject project, there are several factors that affect the cost of construction. The following is a list of those factors:

- Creation of a new emergency department main entrance, at grade, inside the existing attached lower level of the emergency department parking garage.
- As a result of the new entrance existing site utilities in the garage will require interim handling. Existing below grade plumbing/utilities will need to be demolished to accommodate building excavation and foundation elements, but cannot be re-established permanently until the new structure and piping are installed.
- New masonry mechanical and electrical rooms will be required in the parking garage to house a new AHU and electrical distribution equipment for the new emergency department entrance.
- New concrete vehicular ramp and a new concrete pedestrian ramp will be needed to access the new Emergency Department Ambulatory Entrance at the Ground Floor Level
- The project is going to have to be completed in multiple phases requiring extensive interim life safety measures (LSM's) in order to perform construction activities without interrupting the operations of the occupied emergency department as well as to protect hospital staff and patrons.
- The proximity of the project to other critical functions within the hospital is going to necessitate a multi phased multi pronged construction sequence to allow for the renovation to take place while keeping adjacent hospital functions in operation. In addition, several yet to be determined interim phases will also be required as the sequencing is finalized and construction is underway.
- There are numerous utility mains that are routed through the areas of renovation that serve adjacent modalities that will need to remain uninterrupted. As a result of the new piping and ductwork routing temporary ductwork and piping will need to be installed to facilitate the installation of the new work without affecting the adjacent occupied hospital modalities.
- To gain the efficiencies proposed by the redesign of the emergency department several existing I.T. and electrical closets will need to be relocated. As such, redundant temporary I.T. and electrical closets will be required to ensure existing hospital low voltage systems and power remains operational in order to ensure the functionality of adjacent hospital modalities.
- The strategic and measured use of off hours labor will be required to perform shut downs required for the aforementioned I.T. and electric closets relocations as well as for tying into and extending existing utilities from the hospitals utility mains to serve the renovated area. In addition afterhours access to existing occupied hospital modalities, not scheduled for renovation, will be required from time to time.
- Elevators are being added in the center core of the emergency department for the timely and efficient transport of patients from the new emergency department entrance on the lower level to the first floor emergency department. The addition of the elevators is going to require the extensive structural work to the existing building in order to create the new shafts. Existing utilities are also going to need to be relocated in order to create the new shafts without affecting hospital operations.

Respectfully submitted,

PEPPER CONSTRUCTION COMPANY

Andrew J. Kohler
Project Director

cc: File

411 Lake Zurich Road | Barrington, Illinois 60010 | 847 381-2760 | FAX: 847 304-6510

www.pepperconstruction.com

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion

Attachment 39, Exhibit 4, is Advocate Christ Medical Center's calculation of equivalent patient days.

Attachment 39, Exhibit 5 provides actual and projected operating expenses.

Attachment 39, Exhibit 6 provides operating expenses and capital costs per equivalent patient days.

**ADVOCATE CHRIST MEDICAL CENTER
EQUIVALENT PATIENT DAYS**

	Actual 2013	Projected								
		2014	2015	2016	2017	2018	2019	2020	2021	
Patient Days	204,856	206,100	206,700	220,549	225,678	230,807	230,962	232,962	233,962	
Ratio of Outpatient Revenue to Inpatient Revenue										
Inpatient Revenue	\$ 1,958,850,825	\$ 2,043,241,577	\$ 2,120,000,000	\$ 2,287,816,000	\$ 2,364,431,000	\$ 2,442,350,000	\$ 2,468,426,000	\$ 2,504,000,000	\$ 2,525,000,000	
Outpatient Revenue	791,210,575	890,000,000	910,000,000	928,291,000	946,950,000	965,983,000	985,400,000	1,004,000,000	1,014,000,000	
Total Revenue	\$ 2,750,061,400	\$ 2,933,241,577	\$ 3,030,000,000	\$ 3,216,107,000	\$ 3,311,381,000	\$ 3,408,333,000	\$ 3,453,826,000	\$ 3,508,000,000	\$ 3,539,000,000	
Ratio	40.4%	43.6%	42.9%	40.6%	40.0%	39.6%	39.9%	40.1%	40.2%	
Computed O/P Equivalent Days	82,745	89,774	88,725	89,489	90,384	91,287	92,200	93,408	93,955	
Total Equivalent Patient Days	287,601	295,874	295,425	310,038	316,062	322,094	323,162	326,370	327,917	

**ADVOCATE CHRIST MEDICAL CENTER
OPERATING EXPENSES**

	Actual	Projected 2021		
	2013	Medical Center	Project	Total
Salaries and Benefits	\$ 408,029,587	\$ 498,539,557	\$2,520,000	\$ 501,059,557
Professional Fees	41,492,886	54,786,600	-	54,786,600
Services	89,298,626	135,992,990	-	135,992,990
Supplies	164,832,947	201,745,379	405,000	202,150,379
Advocate System Allocations	53,263,163	65,404,248	-	65,404,248
Other	67,504,061	28,200,369	-	28,200,369
Insurance	29,412,513	49,181,530	-	49,181,530
Interest	7,161,935	16,609,586	3,083,000	19,692,586
Depreciation	25,424,655	48,850,000	3,900,000	52,750,000
Total	<u>\$ 886,420,373</u>	<u>\$ 1,099,310,259</u>	<u>\$ 9,908,000</u>	<u>\$ 1,109,218,259</u>

**ADVOCATE CHRIST MEDICAL CENTER
OPERATING EXPENSES PER EQUIVALENT PATIENT DAY
and
Total Effect of the Project on Capital Costs**

	2013		2021 Projected			
	Amount	Per EPD	Medical Center	Project	Medical Center	Project
Operating Expenses	\$853,833,783	2,968.82	\$ 1,033,850,673	\$ 2,925,000	\$ 3,050.60	\$ 8.63
Capital Costs	32,586,590	113.31	65,459,586	6,983,000	193.15	20.60
Total	<u>\$886,420,373</u>	<u>3,082.12</u>	<u>\$ 1,099,310,259</u>	<u>\$ 9,908,000</u>	<u>\$ 3,243.75</u>	<u>\$ 29.24</u>
					<u>\$ 1,109,218,259</u>	<u>\$ 3,272.98</u>

This section is applicable to all projects subject to Part 1120.

XI. Safety Net Impact Statement

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.
2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 43.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Charity (cost in dollars)			
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

APPEND DOCUMENTATION AS ATTACHMENT-40, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

In 2013, Advocate Health Care contributed nearly \$661 million in charity care and services by sponsoring numerous programs and services including, as examples behavioral health services, school based health care, health and wellness screenings and much, much more to the communities it serves.

2013 CONTRIBUTIONS

Charity care and other uncompensated costs	\$527,484,000
--	---------------

Care that is provided free, subsidized, or without full reimbursement from Medicare, Medicaid or other government sponsored programs.

Subsidized Health Services	\$34,144,000
----------------------------	--------------

Services that respond to unique community needs including trauma services, behavior health services health screenings, immunization programs school-based health care and other community outreach programs.

Hospital-Based Education	\$82,307, 000
--------------------------	---------------

Education to train physicians, nurses, radiology technicians, physical therapists and a host of other highly skilled health care professionals.

Volunteer Services	\$6,207,000
--------------------	-------------

Services provided by hospital workers who volunteer in their communities and by community members who volunteer at Advocate hospitals.

Language Assistance Services	\$4,016,000
------------------------------	-------------

Includes providing interpreter services and translation for signage, forms, brochures, patient education materials and information in languages other than English. +

Donations	\$6,611,000
-----------	-------------

Contributions of equipment, supplies, and meeting and clinic space, as well as other assistance to community groups.

TOTAL COMMUNITY BENEFITS CONTRIBUTIONS	\$,660,769,000
--	----------------

Advocate Christ Medical Center (ACMC, Medical Center) provides a significant portion of the System's community benefit efforts and support in the South Market Area.

ACMC's recent capital expansion projects (Ambulatory Pavilion opened March 2014) and Bed Tower (under construction) will increase capacity for safety net services.

It is significant to note that in 2013 ACMC and Advocate Children's Hospital – Oak Lawn delivered care to 81,300 Medicaid inpatients and outpatients.

Advocate Christ Medical Center has shown its commitment to the community through a wide range of initiatives. Among these initiatives are:

- Support to South Suburban Public Action to Deliver Shelter to address the health care needs of the homeless.
- Sponsorship of community outreach; health and disease prevention programs such as health fairs and free health screenings; free medical clinics for underserved patients; nursing camps; support groups; homeless shelters; and school-based health centers.
- Regional Healthcare Coordination Center hospital for coordination of disaster communication/medical resources for seven-county area; involvement in emergency preparedness activities nationally and locally.
- Trains more than 2,500 emergency medical technicians, paramedics and other providers of emergency care each year through the Emergency Medical Services (EMS) Academy – one of the largest training programs in Illinois.
- Partnership with CeaseFire, a Chicago-based outreach anti-violence prevention program.
- Partnership with the Ben Carson Scholarship Foundation to promote higher learning in elementary schools and high schools.
- Partnership with the Museum and Industry, resulting in "Live...from the Heart" – a videoconference-based cardiovascular educational program for young adults.

XII. Charity Care Information

Charity Care information **MUST** be furnished for **ALL** projects.

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer. (20 ILCS 3960/3) Charity Care **must** be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 44.

CHARITY CARE			
	Year	Year	Year
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

APPEND DOCUMENTATION AS **ATTACHMENT-41**, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

CHARITY CARE			
	Year	Year	Year
	2011	2012	2013
Net Patient Revenue	\$ 880,368,000	\$ 862,955,639	\$ 900,774,000
Amount of Charity Care (charges)	\$ 54,888,000	\$ 73,282,846	\$ 97,601,284
Cost of Charity Care	\$ 19,519,005	\$ 20,805,000	\$ 27,468,000
Charity Care as % of Net Revenue	2.2%	2.4%	3.0%

Source: Medical Center Financial Records



Advocate Christ Medical Center

4440 West 95th Street || Oak Lawn, IL 60453 || T 708.684.8000 || advocatehealth.com

October 28, 2014

Ms. Courtney Avery
Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

Re: Advocate Christ Medical Center--Assurances
Section 1110.234 e) 1)

Dear Ms. Avery:

This letter provides the Health Facilities Services and Review Board with assurances regarding our application to modernize the Level I Trauma Center and the Emergency Department and other clinical and non-clinical services at Advocate Christ Medical Center in Oak Lawn.

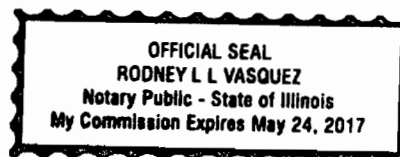
We hereby state that it is our understanding, based upon information available to us at this time, that by the second year of operation after project completion, Advocate Christ Medical Center reasonably expects to operate all clinical services areas included in the application for which there are utilization standards, except the Emergency Department, at the State Agency target utilization specified in 77 Ill. Adm. Code 1110. Appendix B. Because of the unique characteristics of the Medical Center's Emergency Department, the Medical Center used alternative need determination methodologies published by the American College of Emergency Physicians that take into account operational indicators that are not addressed in the State Agency utilization target. These include emergency patient census by hour; percentage of patients admitted; disproportionate share of urgent vs. non urgent patients (higher acuity patient mix); presence of a graduate medical education, an EMS training program, and other teaching programs; special emergency psychiatric services; and special pediatric services. These operational indicators reflect longer average patient times in the Emergency Department because of high acuity and other special patient needs. Longer patient times in the Emergency Department translate into fewer possible visits per room. Based on the American College of Emergency Physicians methodologies, the proposed number of emergency stations is consistent with the volume, acuity and patient mix seen at the Medical Center.

Sincerely,

Kenneth W. Lukhard, President
Advocate Christ Medical Center

Notarization

Subscribed and sworn before me
this 28 day of October, 2014

Signature of Notary

Seal

A faith-based health system serving individuals, families and communities

Recipient of the Magnet award for excellence in nursing services by the American Nurses Credentialing Center

